S. HRG. 103–848

MEDICAL MALPRACTICE AND ANTITRUST ISSUES IN HEALTH CARE REFORM

Y 4. F 49: S. HRG. 103-848

Medical Malpractice and Antitrust I...

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MAY 12, 1994

MAY 23 1995

Printed for the use of the Committee on Finance

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MEDICAL MALPRACTICE AND ANTITRUST ISSUES IN HEALTH CARE REFORM

THURSDAY, MAY 12, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (Chairman of the Committee) presiding.

Also present: Senators Baucus, Rockefeller, Daschle, Conrad, Dole, Roth, Chafee, Durenberger, Grassley and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–34, May 10, 1994]

FINANCE COMMITTEE SETS HEARING ON MEDICAL MALPRACTICE

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on medical malpractice and antitrust issues.

The hearing will begin at *10:00 A.M. on Thursday, May 12, 1994,* in room SD–215 of the Dirksen Senate Office Building.

"The Committee will examine the costs of medical malpractice and the effect that proposed changes in malpractice laws would have on our health care system," Senator Moynihan said in announcing the hearing. "In addition, we will explore the role that antitrust laws should play in ensuring that a reformed health care system delivers quality care and consumer choice at reasonable prices."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our most distinguished witness. Senator Hatfield will be followed by Senator Harkin and Senator Metzenbaum.

Might I just say that this morning we come to the last of our hearings on health care reform and we have been at this a considerable while and we would like to think to some advantage.

The committee held its first hearing on the matter of the administration's health budget on the 1st of April in 1993. So we have been at this for a good deal of time. We have been at it on a sustained, more or less, weekly basis since Mrs. Clinton presented to us the Health Security Act, which as Chairman I had introduced just at that point. This was last fall and there have been regular meetings ever since.

We have, for those who would be interested, there is a list of the hearings. So, as I say, we have heard apart from Mrs. Clinton, Secretary Bentsen, Secretary Shalala, Mr. Panetta, Dr. Reischauer,

five Governors and one-half the physicians and two-thirds the economists in the nation, at least those who address this subject.

We are starting early because we will have a long morning. There will be a vote scheduled at noonday on three measures which will necessarily cause an interruption.

Senator Packwood regrets that he, as is occasionally the case, has to be at the Commerce Committee.

So with the special sense of the honor to have the revered senior friend from the State of Oregon, Senator Hatfield, on hand, we welcome you this morning, sir, and look forward to your speaking to a matter of the utmost importance which keeps recurring in our hearings.

STATEMENT OF HON. MARK O. HATFIELD, A U.S. SENATOR FROM OREGON

Senator HATFIELD. Thank you, Mr. Chairman, and Senator Baucus. I am very happy to be here this morning to make some remarks on behalf of a proposal that Senator Harkin and I have offered to the Senate. I appreciate the opportunity to make my statement at this time in order to attend a 10:30 Appropriations hearing.

Mr. Chairman, I want to speak primarily as an appropriator this morning because in that role I have observed some dangerous signals relating to health research.

In 1993 the Congress for the first time in anyone's memory under-appropriated the President's request for the NIH. Usually the Appropriations Committee has elevated the amount of dollars requested by the President, over and above his request level.

The following year, President Clinton's first budget, was the first time in anyone's memory that the President requested fewer dollars than the current level of spending.

Now taking those two—although the Appropriations Committee corrected the latter, nevertheless the President's request level was below the current level of 1993. With those 2 years and those two indicators, we began to seriously consider how we could stem that particular trend line of decreasing resources that we wanted to nip in the bud.

I might mention that when we look at appropriations, we are spending today about 2 percent of the total health dollars expended in this country on medical research. If you take the $290 billion figure, an annual expenditure, our NIH budget is about $10 to $11 billion. Hopefully, it will be closer to $11 billion this coming year. It has been $10 to $11 billion between 1993, 1994, and 1995.

This is a very small part of the total expenditure for health care when you consider that cost containment depends on medical research that leads to cures or improves treatment.

Let me give you some examples. We consider that in a type of vaccine that we have developed for children against flu, a type B vaccine, that we save on the neighborhood of $359 million annually. And yet the research that led to that flu vaccine was $17.4 million.

Looking at it from an appropriator's point of view, the cost benefit ratio is rather astounding. We could also give you another example. We have developed a laser treatment for diabetic eye problems.

We figure that that now saves us probably about $2 billion a year, this laser treatment. The entire cost to research was $48 million. Again, a demonstration of the cost-benefit ratio.

Let me tell you now about an example dear to me—20 million Americans in some degree are in the process of suffering from Alzheimers Disease. This year we will expend $300 million and it has taken us 8 years to spend $300 million. We started with zero 8 years ago in research on Alzheimers. We are now up to $300 million. But this year the victims of Alzheimers will create a $90 billion cost for care—$90 billion in 1 year.

If you consider then one of the great tragedies in my view is what we call often rare diseases, today there are about 20 million Americans who suffer from orphan diseases. Now these are diseases very rare. There is no registry on the majority of these 5,000 rare diseases. A registry is where they are able to identify through inventory copulation, who and where are such victims or suffers of these rare diseases.

Not even a registry of patients let alone a research project. No research. So we have 20 million Americans suffering from 5,000 plus rare diseases—it may be only 15 people; it may be 1,000; it may be 100. We do not know. But they are out there and have not even been identified in many instances. So I think the need for research is very well established.

Now let me speak again as an appropriator that 51 percent of the dollars that are now appropriated to NIH go to academic health centers. Research and teaching go hand in hand. You cannot really have a full teaching, academic teaching, curriculum be effective without a research component.

So I do not want to get into this situation under the health care programs that are being debated that we have to choose either academic health centers of which the Chairman has nine in his City of New York alone and/or research. I think they really are one and the same.

The CHAIRMAN. We are changing between a teaching university and research university.

Senator HATFIELD. That is correct.

Mr. Chairman, in this proposal we have data from Research America! which indicates broad and vast support for increased research.

The CHAIRMAN. Sir, you and Senator Harkin have a bill you have introduced; have you not?

Senator HATFIELD. We have introduced a bill setting up a National Fund for Health Research. I will just give you a very brief description of it. It provides for 1 percent set aside per month on health insurance premiums.

This is estimated to raise about $4 to $5 billion a year, annually. Once it is fully implemented we would phase it in over 4-year increments of 25-25-25-25. We then would have that trust fund set aside for additional monies for research. It would not substitute for the annual appropriations to NIH.

In fact, if the appropriation level drops below, any 1 year drops below, the current level it would not trigger the trust fund. We are not going to let the trust fund become a substitute. We want it as an additional commitment to the research needs of this country.

Ninety-five percent of that trust fund would be appropriated by NIH to the existing National Institutes on the same formula basis that exists. There is no politicalization, no pitting of one disease against another disease.

Five percent off the top we reserve for the following: 2 percent for the Director of the National Institutes to identify as an additional amount needed because we are moving close to a threshold of a breakthrough in a particular disease. We needed a little more than the average formula would say allocate for that particular year. The Director would be able to add that additional amount to push it through the threshold.

Two percent we would set aside for extramural construction. In other words, we have a deteriorating infrastructure out here across the country in many of our research institutions and on a competitive basis we would provide a certain portion of that trust fund to assist as seed money, particularly for rehabilitation included in NIH's own infrastructure.

One percent we would assign to the National Library of Medicine to maintain the currency of disseminating information, distribution, so forth. Now that basically is the trust fund.

Here you see a poll taken by the Research America! that would indicate 74 percent of the American people said they would be willing to pay $1 more per week in taxes for more health research. Now when you put that in terms of a premium increase, that figure from 74 goes to 77 percent. So I think we have established that there is a very strong public support base.

Lastly, we have included, which is also in Senator Chafee's bill, a voluntary tax check off. In your income tax, if there is a refund, you can check off from the overage for medical research. We have tried this in Oregon—the Legislature in my State of Oregon had adopted the proposition that any Oregon taxpayer based on their income tax could check off an overage for Alzheimers. And based upon that kind of experience we would estimate that between 300 and 500 million more could be available for this trust fund.

If revenue from the checkoff falls below a certain level at any time, we eliminate it. So it is not just one of those things that lingers when it has not proven its worth. We think it will be very popular based upon our own experience in Oregon.

Mr. Chairman, that basically is an outline of both our proposal and the reasons for it, which we think are very, very well established. We have 250 advocate groups—cancer advocate groups, multiple sclerosis, on and on—250 such organizations that have endorsed our proposal to add this kind of resource to health care reform.

I thank you.

The CHAIRMAN. We thank you, sir.

Senator HATFIELD. I would like my full statement in the record at this time.

The CHAIRMAN. Your full statement will be placed in the record.

[The prepared statement of Senator Hatfield appears in the appendix.]

The CHAIRMAN. Could I just ask one detail? You said something important and illustrative. You said that President Clinton's budg-

et for the first time proposed reducing the research subsidies to the NIH.

Senator HATFIELD. That is right.

The CHAIRMAN. That has not happened. It speaks not to the priorities of the administration, but to the necessity of our fiscal situation. We are very short of free sources. We cannot even maintain our own level of effort.

If there is one thing we have learned in a year of hearings, it is that this is the great age of medical discovery and it is taking place in the United States. And to do anything that would impair that, we would not be forgiven by generations to come.

I just want to thank you for your extraordinary attention to this. Could we ask you if you could give us the actual NIH numbers over the years that show this drop?

Senator HATFIELD. Yes.

The CHAIRMAN. As well as the previous one where the appropriations dropped as well.

Senator HATFIELD. Yes.

The CHAIRMAN. Thank you, sir.

Senator HATFIELD. Thank you.

The CHAIRMAN. According to our venerable customs, the Republican Leader is present and we turn to you first, sir.

Senator DOLE. I have no questions. It sounds interesting. I did not get what it would cost. I guess that is the only point I missed. Is there a cost figure? I know you went through the $1 more a week.

Senator HATFIELD. The trust fund would be raised by a 1 percent on monthly premiums being paid now by the American public. A 1 percent set aside for this trust fund.

There are those who say, does this constitute a new tax? I do not think it necessarily has to constitute a new tax. I would not be opposed to it if it did. I think that the 1% can come from the administrative costs incurred by insurance companies. We have at least some who have, speaking from authority, say they felt 1 percent could be squeezed out of the actual administrative overhead of those premiums.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Senator, I am just curious, just out of curiosity, do you off the top of your head know approximately what portion of the NIH research is devoted to preventive medical care as opposed to research in remedial medical care?

Senator HATFIELD. Sometimes it is very difficult to delineate between what is a cure and what then relates back to a prevention. The medical research dollar today is fundamentally going to discover the cause of such disease or such problems.

The preventive programs relating to the current debate and so forth, I think you would find more in other agency's roles, such as HHS, Department of Education, so forth and so on. But I do not know that you really can again separate that completely between prevention and cause.

We know, for instance, today the cause of lung cancer, a part of the cause of lung cancer, not entirely. What we do with that information then becomes the real core of prevention. There is an awful

lot that we do know that we are not utilizing for prevention of disease, whether it is involving tobacco, whether it is involving life style, or whether it is involving exercise or so forth.

We have had tests show that somewhere in the neighborhood of 75 to 80 percent in the Massachusetts General Hospital at any given moment are in there by their own actions, whether it be obesity, diet, exercise, tobacco, alcohol.

But basically to answer your question, the major dollar, part of that dollar, goes to discovery and to investigation. For instance, in the GENOME project today, we are moving rapidly on isolating the breast cancer gene. These are things that could be very preventive in the past because once we do that then by a blood test we can give the projection of the odds of any woman expecting to have breast cancer at some future date not having to wait for the lumps to appear before they identify it.

So that is a prevention and yet that comes through basic research of the genetic mapping.

Senator BAUCUS. Thank you very much.

The CHAIRMAN. Thank you, Senator Baucus.

Senator Grassley?

Senator GRASSLEY. I have no questions of this witnesses. Thank you very much for your leadership in this area of research.

Senator HATFIELD. Thank you.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I am delighted to see our good friend here, Senator Hatfield. He and I have talked about this to a considerable degree. As Senator Hatfield mentioned, we have this check off in our program and I think he makes a very, very good point.

The CHAIRMAN. He sure does.

Senator CHAFEE. I always find that when I agree with somebody I consider that point is very well taken. [Laughter.]

The CHAIRMAN. Particularly when you agree with Senator Hatfield. That is a little extra insurance in that.

Senator Hatch?

Senator HATCH. Thank you for your comments, Senator Hatfield, they have great weight with me. As we look at research, I think that we ought to give some incentives as we did under the original orphan drug legislation. In 1983, we only had 10 orphan drugs, and today there are almost 600. That was with a very limited expenditure by the Federal Government, which provided the incentives to the private sector to find these cures.

I think we need to do both and I have been a strong supporter of what you are talking about. I appreciate your testimony today.

The CHAIRMAN. Thank you, Senator Hatch.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

Welcome, Senator Hatfield. I have just been going through your testimony and I think it is a real contribution to the work of the committee and I am very pleased that you have focused on this issue, because research is critically important to any health care plan that we devise.

Senator HATFIELD. That is right.

Senator CONRAD. I just had an opportunity to be at Stanford University over at the research facility and saw them working on a method of preventing cancer by taking the cells from an individual and using it to develop a medication where they could reintroduce those altered cells into somebody that is suffering from cancer to fight the cancer to immunize a person against their own cancer.

It is remarkable the success that they are having—albeit on a limited test trial. Nonetheless, it is the kind of promising application that we want to make certain we are able to pursue. So I again want to add my voice to thanking you for being here today and for the thoughtful presentation you have made.

Senator HATFIELD. Thank you, Senator.

The CHAIRMAN. Well, Senator, thank you. You have just five minutes to get to the Appropriations.

Senator HATFIELD. Thank you, Mr. Chairman.

The CHAIRMAN. We thank you very much, sir.

We are in a not unfamiliar situation in which is generally classified "the Senator is on his way." Senators Harkin and Metzenbaum are due to arrive any moment. Rather than start a panel, if it is agreeable to the committee, I think we would just stand in recess for a few moments. We are waiting for Senator Metzenbaum and Senator Harkin. They are on their way, literally.

Senator BAUCUS. From where?

The CHAIRMAN. From Ohio and Iowa.

If the committee wishes we can put a panel on.

Senator CHAFEE. Let us go ahead.

The CHAIRMAN. Charge ahead, says the former Marine. And, therefore, we will have our first panel come forward, please. You have to understand you will be interrupted very briefly.

Our first panel is on the subject of malpractice which is a matter we are going to have to address. Dr. Troyen Brennan is Professor of Law and Public Health at Harvard School of Public Health at Harvard Medical School. Come forward, please.

Jacqueline Corrigan, who is the Senior Analyst of the Office of Technology Assessment. Clifton Cleaveland, the President of the American College of Physicians. It is a great honor to have Dr. Cleaveland with us.

Dr. John Herbert Niles on behalf of the Health Care Liability Alliance. And Philip Corboy, Attorney, who is Chair of the Special Committee on Medical Professional Liability appearing on behalf of the American Bar Association.

We welcome you all. Dr. Brennan, would you proceed, sir?

STATEMENT OF TROYEN A. BRENNAN, M.D., J.D., M.P.H., PROFESSOR OF LAW AND PUBLIC HEALTH, DIRECTOR OF THE PROGRAM IN LAW AND PUBLIC HEALTH, HARVARD SCHOOL OF PUBLIC HEALTH, ASSOCIATE PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, BOSTON, MA

Dr. BRENNAN. Good morning. Most of the reform proposals currently being considered by the Senate contain provisions for Federal tort reform.

The CHAIRMAN. All statements will be placed in the record as if read. We will proceed exactly on schedule. Dr. Brennan.

Dr. BRENNAN. Thank you.

Regarding reform proposals the Administration, for instance, recommends mandatory but nonbinding alternative dispute resolution mechanisms, requires plans to submit certificates of merit before initiating suits, limits contingency fees to 33⅓ percent, requires mandatory collateral source offsets and periodic payment mechanisms, and recommends experiments with exculpatory use of practice guidelines and enterprise liability.

These reforms are intended to reduce rates of malpractice litigation. But making it more difficult for plaintiffs to sue should not be the sole response of the country to problems of medical malpractice.

Tort litigation is intended to compensate individuals who have been injured and deterred practices that lead to injuries. Most of the Federal proposals will not improve the ability of this tort system to undertake these critical functions.

In this testimony I'd like to introduce recent empirical evidence that puts the Health Security Act and other Federal malpractice reform proposals in perspective. I have addressed other issues in my written testimony, but here I will make three simple points.

First, medical iatrogenic injuries are associated with significant morbidity and mortality and large costs. We analyzed over 30,000 medical records in the State of New York for care rendered in 1984 for the care for those 2.6 million people who were discharged from those hospitals and we found that amongst those people 98,000 suffered adverse events defined as injuries caused by medical practice as opposed to disease process—27,000 of these were due to negligence.

The overwhelming majority of adverse events led to minimal impairment or short prolongation of the hospitalization. However, 2,500 of these injuries cause permanent impairment. In addition, medical adverse events were associated with 13,000 deaths. Of these deaths nearly 7,000 were caused by negligence or failure to meet the standard expected of the reasonable medical practitioner.

These adverse events were associated with great costs. In 1984 dollars adverse events costs $1.8 billion in medical care. If the medical care costs are adjusted in 1993 dollars and extrapolated from New York to the entire country, medical injuries are associated with $60 billion in costs, all of which the medical care system today silently absorbs.

Reimbursement for medical malpractice liability insurance covers very little of these costs. This figure of $60 billion is larger than the combined estimates of the cost of medical malpractice premiums which are about $10 billion and defensive medicine, the estimates of which range between $10 and $20 billion.

The costs of medical injuries and the total morbidity mortality associated with adverse events and adverse negligent adverse events underlines the need for greater efforts aimed at prevention of medical injuries.

This matter of great public health importance is not clearly addressed by the Health Security Act or other suggested Federal reforms. The failure to address prevention is the single greatest weakness of current Federal reforms of malpractice.

My second point concerns access and quality of care. Medical injuries are unevenly distributed. The major individual socioeconomic

risk factor for suffering a negligent medical injury is lack of insurance.

In this regard, the President's insistence on universal access is critically important. Clearly, quality of care is linked to ability to pay and any moderation in the commitment to universal access will prolong the two-class care system that exists in this country today.

My third point is that medical malpractice claiming is not matched to medical injuries. A review of over 68,000 medical malpractice claims in New York State uncovered 3,600 claims that arose from the treatment year 1984. Since each of the 27,000 negligent adverse events we found theoretically could and should give rise to medical malpractice claims, it appears in only one out of seven potential claims are actually being brought.

Matching the claims to medical records provides an even starker statistic. Over 80 percent of claims are brought in cases in which there is no adverse event or no negligence. Those are inappropriate claims. On the other hand, less than 3 percent of negligent injuries leads to claims. This means the medical malpractice system is very inaccurate. Indeed, it is similar to a situation in which a traffic officer is giving tickets to large numbers of motorists who are not speeding, but failing to give tickets to many speeding motorists.

The Health Security Act, insofar as it emphasizes mandatory collateral source offsets and use of guidelines for exculpatory purposes, will reduce overall claiming. As a result, it is likely to reduce some of the false claims, those brought in cases in which there is no injury, and it will also reduce claims brought in cases in which there was a negligent adverse event.

Therefore, it will further minimize the already scanty compensation available to the majority of injured patients who were injured as a result of negligence. Alternatives like the malpractice package contained in the Managed Competition Act of 1993, for instance, will bring even further reduction of claims.

Given the deficiencies of the present system and yet the incredibly high morbidity and mortality associated with medical injuries, it hardly makes sense simply to reduce claims. This will only lead to less compensation for and deterrence of medical injuries.

Rather, Congress should fund demonstration projects of alternatives to tort litigation, like enterprise liability and no-fault methods. These alternatives have significant theoretical advantages over the present system and must be evaluated.

As health care reform proceeds, serious consideration must be given to rational medical malpractice reform. Thank you very much.

[The prepared statement of Dr. Brennan appears in the appendix.]

The CHAIRMAN. Dr. Brennan, that was an extraordinary performance for a man who is both a doctor and a lawyer to finish ahead of time. [Laughter.]

That was a striking statement. In your research it was New York data, I gather, in which you found that 80 percent of claims brought in malpractice cases were cases in which there was no adverse event or no negligence.

Dr. BRENNAN. That is correct.

The CHAIRMAN. We will get to this in questioning. That is impressive.

Ms. Corrigan on behalf of our own OTA. Good morning. We welcome you.

STATEMENT OF JACQUELINE A. CORRIGAN, J.D., SENIOR ANALYST, HEALTH PROGRAM, OFFICE OF TECHNOLOGY ASSESSMENT, WASHINGTON, DC

Dr. CORRIGAN. Good morning. Thank you, Mr. Chairman. I am submitting our written statement for the record. I am happy to have the opportunity to present OTA's findings on the impact of medical malpractice reforms on malpractice costs.

My testimony today is drawn from a background paper done as part of OTA's study on defensive medicine and the use of medical technologies. The primary requesters of that study were Congressman Bill Archer and Senator Orrin Hatch. Other members of our Technology Assessment Board, including Senators Grassley and Durenberger, also requested this assessment.

In the past 15 to 20 years virtually every State has enacted one or more medical malpractice reforms. The objective of the reforms were mainly to lower the direct costs of the medical malpractice system and, hence, malpractice premiums.

Many of the reforms adopted by the States—caps on damages, collateral source offsets, changes in the statutes of limitations, and pre-trial screening, at least in principal, made it harder or more expensive to sue and lowered the allowed payments when plaintiffs were successful.

Whether the reforms reduce direct malpractice costs in practice was empirical question we examined. We analyzed a total of six studies that examine the impact of specific reforms on one or more indicators of malpractice costs, including frequency of suit, payment per paid claim, and malpractice insurance premiums.

Two reforms—caps on damages and mandatory offset of collateral sources of compensation—were found to consistently reduce one or more indicators of medical malpractice costs.

Some reforms were found to have mixed results across studies, others showed no impact. The failure to find an effect of some reforms in direct costs may result from several factors. The effects that were modest in size are unlikely to be detected by these studies. Reforms such as periodic payment of damages should only affect a small number of claims and have modest impacts.

In addition, some reforms as implemented were not very strong. Statutes imposing a cap on attorneys fees typically limited the fees to one-third of the award—the average attorney fee absent reform. Other limitations are discussed in our written statement.

The bottom line is that we can say with some confidence that caps and damages and mandatory collateral source offsets will reduce direct malpractice costs, other reforms may reduce costs, especially when implemented as a package, but their impact may be quite modest when compared with caps on damages and collateral source.

However, if the objective is to reduce health care costs, malpractice reforms that affect only direct costs will not make a dent.

Direct costs of compensating patients injured by medical malpractice are less than 1 percent of health care costs overall.

In addition, some reforms that have a measurable affect on direct costs may be the reforms that most limit access for plaintiffs by reducing their potential award for placing the burden of cost savings on a small percentage of plaintiffs who are most severely injured.

In addition, certain reforms may have a disproportionate impact on access by low income plaintiffs, a population that tends not to seek legal redress for their injuries.

There are a number of new reforms, some of which are just beginning to be tested in a few States. These include the use of clinical practice guidelines as a standard of care, enterprise liability, binding alternative dispute resolution and selective no fault.

Proponents of these reforms claim that each of these proposals has a potential to relieve physicians of some of the anxiety about a malpractice claim and may therefore reduce costs by reducing physicians' incentives to practice defensive medicine—that is, physicians' use of medical technologies to avoid the cost disruption and discomfort of being sued.

The strengthens and weaknesses of these arguments are discussed in our final report. Sufficed to say, however, that the potential impact of these new reform proposals on physicians' clinical practices are based on logic, not experience.

Whether and by how much physicians tailor their practices to avoid malpractice liability is the subject of OTA's final report. To date, only one published study has documented higher cesarean section rates by obstetricians practicing in New York hospitals in areas that experience high malpractice claims and high malpractice insurance premiums.

Whether this finding can be generalized to other specialties and States is not know. Medical malpractice reform is being proposed as part of a comprehensive health care reform package that will likely have as one of its central goals control of rising health care costs.

At present, the pressure to practice defensively occurs in a health care system that in large part imposes no financial penalty on doctors and often compensates physicians when they use medical technologies. Under a different payment regime—for example, a managed competition system—providers are likely to have an incentive to consider the costs of practicing defensive medicine against the opportunity to reduce their risk of suit. Physicians may, therefore, practice less defensive medicine even in the absence of tort reform.

In conclusion, tort reforms that only affect direct costs are not going to have a substantial affect on total health care expenditures and may lead to reduced access to compensation for injured patients. One potential avenue for malpractice reforms to reduce health care costs is through a reduction in defensive medicine.

This is only possible, however, if, one, defensive medicine adds significantly to health care costs; and two, malpractice reforms lead to a reduction in defensive medicine. Our final report will focus on these two questions.

Thank you.

The CHAIRMAN. Once again, on time, under budget.

[The prepared statement of Dr. Corrigan appears in the appendix.]

The CHAIRMAN. Those are two very important points. Does defensive medicine significantly add to costs; and will malpractice reform lead to reduction of such practice?

For that, we hope you would comment on that and other things, Dr. Cleaveland, on behalf of the American College of Physicians. It is an honor to have you here. We welcome you, sir.

STATEMENT OF CLIFTON R. CLEAVELAND, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, CHATTANOOGA, TN

Dr. CLEAVELAND. Thank you, Mr. Chairman. I do not believe there is another profession whose practitioners have to fear every single day that any action they take may subject them to the terrifying emotional and financial peril of a lawsuit. What would it do to the institution of the Congress if every vote were grounds for a personal legal challenge?

The CHAIRMAN. We are getting there. [Laughter.]

Dr. CLEAVELAND. Well, I suggest that it would invade every decision that you make; and it would pervert the very ideals that you have sworn to uphold.

The malpractice situation perverts the ideals that I as a physician have sworn to uphold. This Congress has the opportunity to change that.

I am an internist in full-time clinical practice and I deal with uncertainty continually. Be it chest pain, headache, fever, night sweats, any disease can present with a wide variety of symptoms. It is my job to tease out the symptoms to identify a cost effective safe therapy and to come in under budget, and the budgets are tighter and tighter.

Consider a patient with chest pain. A 40-year-old man comes to me with chest pain. I evaluate him and my conclusions are that it is not a serious problem. I wait. I observe. I stay in touch with the patient. But what if I miss a heart attack? What if the patient should die? This very scenario has led in my State of Tennessee to the recent filing of a $20 million lawsuit against a very fine physician.

Human biology is fraught with uncertainty. There is no such thing as complete data and the results of our tests are often inconclusive. But patients expect instant answers. They want to know now. They want the full array of diagnostic tests which they have heard about from television to be brought to the service of themselves and their loved ones.

This insistence of patients for the latest and most spectacular high tech, together with my fear of litigation, means that I am under constant pressure to obtain comprehensive tests, even if in my clinical judgment, these tests may be unwarranted.

Because of such pressures, we physicians rarely have time to use one of our most important diagnostic tools, and that is careful observation over time. The current climate in malpractice litigation further adds to the tension between me and my patients.

Repeatedly, I am asked by my patients and their families to obtain a particular test with the implied threat that if I do not and something happens to that patient I will be taken to court. Instead

of being allies against the common threat—human illness and injury—too often the patient and I are placed in adversarial roles.

Because of the often exaggerated claims for high tech interventions, patients and families expect that everyone will recover from every condition. A fatal or bad outcome is sometimes the natural consequence of overwhelming illness, such as cancer or massive cerebral hemorrhage.

Every single one of my clinical colleagues acknowledge that they practice defensive medicine routinely and extensively. Every patient encounter must be looked at from the standpoint of how this case will look under cross examination in court.

But even more disturbing is the sense of mistrust which pollutes the health care environment today. As we move progressively toward cost restraints implicit in managed care programs, the role of a physician is even more stressful.

Clinical judgment in such circumstances is held hostage to often arbitrary guidelines dictated from afar. Every single patient encounter under managed care becomes a moral stress test for the physician.

To address these and similar problems, the medical profession has united in supporting as a first step the tort reforms outlined in our written statement—a cap on non-economic damages, elimination of joint and several liability, offsets for awards from collateral sources of recovery, reasonable limits on statutes of limitations, and a sliding scale for attorney contingency fees.

Beyond these, the College urges you to include provisions to require pretrial screening, to strengthen alternative dispute resolution methods and study the use of no fault approaches. Malpractice reform should not be seen as a battleground between physicians and patients. We waste tons of money under the present situation and we do nothing to improve the quality of care.

We hope that the Congress and the advocacy groups who speak for consumers, as well as physicians, will view liability reform as a win/win issue for all of us and that we can all come together on a significant package of reforms.

Thank you very much.

[The prepared statement of Dr. Cleaveland appears in the appendix.]

The CHAIRMAN. We thank you, Dr. Cleaveland. We have after 1 year of hearings we have broken our record. Three successive witnesses telling us very important testimony and coming in under the wire.

Senator DOLE. Mr. Chairman?

The CHAIRMAN. Sir.

Senator DOLE. In the event I am not able to stay because we have an amendment on the floor, if Dr. Cleaveland or somebody could furnish a typical case in the typical defensive medicine you practice. We all use the terms defensive medicine but nobody has ever told me what it really is. Maybe they are different in different cases. But that would be very helpful.

The CHAIRMAN. Yes.

Senator DOLE. What are these? How many tests are there and what are they and why are they defensive? I think that would help some of us who sympathize with the problem.

The CHAIRMAN. Do you have a moment to expand on this?

Dr. CLEAVELAND. My patient with chest pain, if I see and take a history, and physical, and obtain an EKG, and an exercise stress test, we are dealing with dollar amounts of approximately $200. An isotope angiogram, an isotope technique will come in at $1,500 to $2,000 and it still gives incomplete answers.

A cardiac catherization, including physician fees and hospital fees as an outpatient, $3,500. So we are dealing with $200 on one hand versus amounts that may reach $3,500 to $5,000 to evaluate chest pain.

I could break the bank if I exposed every chest pain patient to the full bevy of diagnostic tests and yet none of these give definitive answers. The only definitive answer we obtain with heart attacks for instance is often the autopsy.

Senator DOLE. It is a little late then. [Laughter.]

The CHAIRMAN. That is why doctors used to speak only Latin.

Senator DOLE. I think that is very helpful. There are other examples, too. In other words, you are suggesting you could do it for probably the cost of about $200. But if you wanted to go the full range for protection you would have to spend another $500. Is that fair?

Dr. CLEAVELAND. I think you would be up in the several thousand extra if you wanted to go all the way and make your case as litigation proof as you could possibly construct it.

The CHAIRMAN. But you are also saying that the probability of definite information does not rise that much.

Dr. CLEAVELAND. It improves.

The CHAIRMAN. Improved.

Dr. CLEAVELAND. But it is never 100 percent full proof.

Dr. BRENNAN. A better example might be with a caesarean section. Doctors are very worried, obstetricians, about being sued. Often the safest thing to do if the monitor strips look bad for the infant is to go ahead and do a caesarean section.

It has been demonstrated that independent of all other factors in areas where there is high litigation, there is more C-sections. So what you see is the affect of litigation driving up the C-section rates. The C-sections obviously cost a great deal more, probably three times as much as the normal vaginal delivery would.

So the doctor is trying to be safe and as a result driving up health care costs.

The CHAIRMAN. And that was your research in New York?

Dr. BRENNAN. That came out of our research in New York. There is not much—there are a lot of analogies and anecdotes about defensive medicine. But it is very difficult to demonstrate defensive medicine at the level of empirical research.

The CHAIRMAN. But you found such an incident?

Dr. BRENNAN. This we did find and the OTA has made several other efforts to try to track down defensive medicine.

Senator CHAFEE. Could you give a dollar figure, just for example, on a C-section versus a normal delivery, just as an example of what you are talking about in dollars.

Dr. BRENNAN. You mean, how much does it cost to do a vaginal delivery as opposed to a C-section?

Senator CHAFEE. Yes.

Dr. BRENNAN. I cannot give a very accurate one. I would say probably the difference between $1,600 and $3,200. But that varies a great deal from State—to-State.

Dr. NILES. I can answer that for you, Senator Chafee. A C-section, as far as the physician fee, many insurance carriers are now paying you the same reimbursement for a vaginal delivery as they pay for a C—section. The additional cost comes in the additional days in the hospital. Those are the costs that probably run maybe another—you just double whatever the hospital rate is. That would be the number different.

So if the hospital stay, say, is $1,000, it would cost you another $2,000 to affect a C-section. But as far as the physician reimbursement level, it is essentially the same cost.

The CHAIRMAN. To a layman that is a coherent response, Dr. Niles.

Dr. NILES. All right.

The CHAIRMAN. You spend an extra day in the hospital because you have had an operation.

Senator CHAFEE. Well, I am surprised at that. I would think that the physician reimbursement should be different. I mean, a regular delivery that the doctor wanders in and does not do an awful lot, from my experience——

Senator DURENBERGER. Mr. Chairman?

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. I am a rank amateur at this, but yesterday I was a grandfather and I was not there. It happened 1,000 miles away in St. Paul. For whatever reason, the doctor made the decision that my daughter-in-law would deliver by caesarean.

I can tell you that compared to the delivery for my four sons, the doctor's part of this was relatively simple by comparison. I think it took about 15 minutes or something like that.

But you are right, the hospital stay will be at least 3 days and it depends on the condition of the mother, and the condition of the delivery.

The CHAIRMAN. Your grandson is in good shape?

Senator DURENBERGER. Granddaughter.

The CHAIRMAN. Forgive me.

Senator DURENBERGER. Granddaughter, 8 pounds, 5 ounces, 21 inches long. The most beautiful baby in the world. Big feet.

The CHAIRMAN. It is definitely above average.

Senator DOLE. How does she stand on health care? [Laughter.]

The CHAIRMAN. Well, congratulations to all concerned.

We will have general conversation after we have two more witnesses. So why do we not ask Dr. Niles who has already joined the conversation.

Good morning, sir. You are appearing on behalf of the Health Care Liability Alliance.

STATEMENT OF JOHN HERBERT NILES, JR., M.D., F.A.C.O.G., ON BEHALF OF THE HEALTH CARE LIABILITY ALLIANCE, WASHINGTON, DC

Dr. NILES. Good morning, Mr. Chairman and Senators. I just want to make one personal comment. Senator Moynihan, you spoke

at my graduation from Medical School at Howard University. We will not say how many years ago that was.

The CHAIRMAN. No need for either of us, yes.

Dr. NILES. And I worked with—probably Senator Durenberger does not remember, we did some——

The CHAIRMAN. He does, indeed, remember, sir. He was insistent that you appear.

Dr. NILES. That we did some hearings on infant mortality here in the District of Columbia at Providence Hospital.

And we have had discussions with Senator Hatch on this issue as well. So I feel a little more comfortable—not a lot—but a little more comfortable seeing so many familiar faces.

First, I want to thank you for the opportunity to testify. I am John Herbert Niles, M.D., a solo practitioner in private practice here in the District of Columbia, and a Board Certified Obstetrician/Gynecologist. I have been in practice for the past 24 years.

I would like to discuss in my brief time that I have been allotted two issues—access to care and fairness as it relates to the health care reform legislation. Our written statement has been supplied in advance.

The CHAIRMAN. And will be placed in the record.

[The prepared statement of Dr. Niles appears in the appendix.]

Dr. NILES. All of the associations that I am currently a member—the American Medical Association, the National Medical Association, and the American College of Obstetricians and Gynecologists—have endorsed or supported components of comprehensive medical liability as described in President Clinton's Health Security Act.

The most significant proposal is missing in the President's plan, and that is a cap on non-economic damages. I support a cap of $250,000 which is in the current limit imposed in California and also is listed in the Chafee-Thomas bill.

As an obstetrician and especially that as a high risk for potential and neurological injuries, the absence of a cap on non-economic damages will not contain the costs of health care liability premiums for my specialty. I was very interested in hearing the comments made earlier in testimony that it has been demonstrated that is a valid determination in reducing premiums.

Universal access to health care is the stated major component of health care reform as presented by the President and Mrs. Clinton, particularly the access to quality prenatal care in a nation with the highest infant mortality rate in the industrialized world that requires the services of highly trained and experienced practitioners.

In studies performed by the National Academy of Sciences, the Southern Legislative Conference, and our own District of Columbia Intergovernmental Relations Affairs Office have concluded that "the availability of OB providers is decreasing and this decrease is having a disproportionate affect on the availability of obstetrical care for poor women and Medicaid patients."

I will also quote directly from the Southern Leadership Conference study which was performed and completed in June of 1990. In that summary they state, "Additional tort reforms have been partly successful in some States in ensuring the availability of medical malpractice insurance and in limiting costs and increases.

Current tort reforms have not stemmed the exodus of obstetrical providers from the field and some solution is needed to ensure that pregnant women have access to good prenatal care."

The CHAIRMAN. Dr. Niles, if you do not mind and interruption, you said exodus.

Dr. NILES. Yes.

The CHAIRMAN. People are leaving the field?

Dr. NILES. That is correct.

The CHAIRMAN. We have not heard that before.

Dr. NILES. And you will see in our testimony it is documented.

The CHAIRMAN. Not just people are not entering, but people are actually leaving.

Dr. NILES. Well, the entering is a problem. It is a lot easier to document those that are leaving because people have indicated in surveys from the American College that they are curtailing practice and leaving at an earlier age than they would otherwise because of the situation.

Next, I would like to discuss the issue of fairness. The current hodge-podge of medical liability laws in different States is unfair to all physicians and there needs to be a uniform national legislation so that, for example, the OB physicians in the District of Columbia do not pay twice as much in malpractice premiums as physicians in the State of Virginia currently pay or 40 percent more than the physicians in the State of Maryland currently pay.

The physicians in Florida, costs for liability far outweigh the costs in the State of South Carolina.

I will give a personal example of an additional point as it relates to fairness. Currently the statute of limitations varies from State-to-State and there are about 30 States that have varying degrees of statute of limitations.

However, the District of Columbia which has no tort reform at all, has no statute of limitations, the statute currently is 21 years for birth-related cases. It would be 3 years for any other incident, but 21 years for birth-related.

Three weeks ago I received a letter from our hospital Medical Records Department advising me that a law firm had requested the medical records on a baby I delivered in December of 1973. I do not have in my possession a copy of that chart.

The CHAIRMAN. Did everybody hear that?

Dr. NILES. I have the letter right here.

The CHAIRMAN. Would you place that in the record?

Dr. NILES. I sure would. The only thing about confidentiality, I do not want to get sued for giving the information out.

The CHAIRMAN. Well, then do not place it in the record. [Laughter.]

Dr. NILES. But certainly someone will advise me, and I will ask staff to advise me on how we can correct that so that we can document that fact.

I do not have that particular patient's chart in my possession. Fortunately, Columbia Hospital has maintained a copy on microfilm of that medical record and the delivery turns out to be uneventful. I feel a lot better after reviewing the chart, seeing that it was a normal vaginal delivery, APGARS of 9 and 10. There was no problem.

In the 24 years that I have been in practice, I have had one malpractice action against me. It was brought back in 1982 and it was not an obstetrical case.

Senator CHAFEE. It was not?

Dr. NILES. Not an obstetrical case.

Next, under the fairness issue, particularly as it affects providers under the proposed health care reform is the following facts. Because of cost containment factors in current managed care, there are increasing attempts to contain provider reimbursements, in spite of continuing increases in our overhead costs, such as liability insurance, employee salaries and even rent.

As a minority physician provider, these increasing costs particularly impact on my ability to continue the practice of high risk obstetrics. Many minority practitioners receive reduced reimbursements because they have historically and uniformly provided care to low income patients, including Medicaid patients.

I would urge the Congress in their deliberations on health care reform legislation to please place in the final legislative provisions that would significantly address health care liability so physicians can continue to practice in the new cost containment environment.

I would urge the Congress to enact health care liability legislation based on the California model and proposed provisions in the Chafee-Thomas bill, interestingly co-sponsored by Senator Dole, Senator Hatch, Senator Danforth, Senators Grassley, Durenberger and Boren.

The CHAIRMAN. You are doing very well there.

Dr. NILES. Thank you, Senator. [Laughter.]

Again, thank you for giving me the opportunity to share these views. I would be happy to answer whatever questions that I can.

The CHAIRMAN. Thank you, Dr. Niles.

And now for the defense. I think Mr. Corboy is Chair of the Special Committee on Medical Professional Liability of the American Bar Association and appearing on their behalf. Good morning, sir.

STATEMENT OF PHILLIP H. CORBOY, J.D., CHAIR, SPECIAL COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY, ON BEHALF OF THE AMERICAN BAR ASSOCIATION, CHICAGO, IL

Mr. CORBOY. Thank you, Mr. Chairman and other Senators. You have described me accurately as Chairman of the Special Medical Malpractice Committee of the American Bar Association. But I think it would be somewhat discourteous to all of you, and somewhat disarming to those who know me, to not also inform you that in addition to that hat I may have some horns.

Those horns are supplied by my identity as a Plaintiff's personal injury wrongful death lawyer. I engage every day on a daily, weekly, monthly basis representing Plaintiffs whose husbands have either been killed, or they themselves have been maimed, or they become fatherless. So I want you to know that my bias was not hidden.

By the same token, the American Bar Association has been on record since 1972 for universal health care and availability to everybody in the country, despite absence of income, despite poorness or wealth or anything else. So we are not new to this subject.

With reference to the tort system, we are not Johnny Come Lately to that area of the law either. In 1986 a special committee was appointed to study the medical malpractice issues with no anticipation that there would be federalization of that issue. That went before the 380,000 representative government of the ABA and came out with the conclusion that yes there was some room for improvement, but it should not be done on a Federal level, that if any improvements were needed, if they were needed, they could be done by the States.

Subsequent to that, specifically I believe, in 1987, there was an Action Commission To Improve Tort Liability System appointed in the ABA. Now the difference between a commission and a committee in the ABA is that a committee is internal and the representatives of that committee are taken from the 380,000 members at large. A commission has outsiders in it. They have consumer representatives, they have insurance representatives and so forth.

They came out with various recommendations and our House of Delegates adopted a resolution based on them that is in our report to you. Not the most undisciplined, not the most obvious was that recommendation that if there were to be any changes in the malpractice law that they be confined to the States' activities.

Now I this morning would like to point something out to you. I know it has been a long time since Erie versus Tomkins, but despite that the Federal Government is not in the common law business, at least most of the cases say they are not in the common law business.

We respectfully suggest that federalization of the medical malpractice laws of this country will supply problems, but with no Federal cause of action. Keep in mind, you cannot go to the Federal court unless diversity exists and seek remedy if you are an injured person.

The problems of the 55 States, and Districts, and territories supplied by national law, I suggest, will be unsurmountable. We would be starting from scratch with what would actually be a Federal statutory law imposed upon the common law of the 55 States and territories.

Keep in mind also that the last arbiter of those issues would be the Supreme Court of the United States. The Supreme Court of the United States would be determining attorneys fees. The Supreme Court of the United States would be determining guidelines. The Supreme Court of the United States would be determining whether there was or was not negligence, and whether there was or proximate cause.

I do not think the Supreme Court of the United States wants those issues. I respectfully suggest that the Federal District Courts do not want malpractice cases. They do not want any diversity cases. They would like to get rid of the whole shebang.

So I respectfully suggest to all of you that medical malpractice laws be left to the States. They have done a good job of it. They understand the local customs. They understand the local needs. And I respectfully suggest they have done a good job of it.

Many of the reforms suggested by all of the bills from Mr. Clinton's bill, Mrs. Clinton's bill, excuse me, all the way down to Senator Chafee's bill.

Senator CHAFEE. Please do not say all the way down to. [Laughter.]

Across to.

Dr. CORBOY. Also, Senator, I have indicated another bias. I'm a Democrat. In any event, whether it is up or down, I respectfully suggest that the States can do it.

Senator DOLE. Would you put in the record what the States have done? That would be helpful.

Dr. CORBOY. Well, I can give you the American Medical Association's report and that of the OTA on what was done. I am one of those lawyers that does not know how to turn pages. I can give you a list of all reform State-by-State.

I might point this out to you,and I say this with complete respect for the doctors——

The CHAIRMAN. We will place that in the record.

[The information appears in the appendix.]

Dr. CORBOY. I point this out to you. I do not understand at all the term defensive medicine. I say this recognizing that I will be criticized all over by anybody hearing this. I respectfully think defensive medicine is malpractice. If the only reason to give a procedure is to allay the fear of malpractice, it should not be done.

Incidentally, the tests that the doctor here suggested a few moments ago that he gives because his patients want them, if he gives those tests and something bad happens, yes, that patient is going to sue him and he should sue him or she should sue him.

The CHAIRMAN. You mean Dr. Cleaveland?

Dr. CORBOY. Yes, sir.

I do not believe there is any plausity of obstetricians in the country. We have the figures which indicate that in 1980 there were 10,000 new obstetricians who received certificates. As of July 1991 there were 25,000 Board Certified physicians, obstetricians, gynecologists. I do not think there is a shortage of obstetricians. There may be a shortage of obstetricians in Kayro, Illinois. There may be some in some rural areas. But there are no shortage of obstetricians where obstetricians can deliver babies and be paid for it.

I also respectfully suggest that the question of caps is a red herring. If doctors are afraid to practice medicine without engaging in defensive medicine, if they are told that the most plaintiffs can get for pain and suffering awards is $250,000, are they going to stop that defensive medicine? I query that. Are they going to say only because my damages are limited now I am not going to engage in it or are they going to continue to inform insurance companies that they are going to engage in defensive medicine.

I also suggest to you, look carefully as to who pays and who benefits from the costs of this term defensive medicine.

Am I over?

The CHAIRMAN. I think, sir, if I could say, why do you not stop there and we will questions in which you join in the responses.

Dr. CORBOY. I thought you were going to give me the time they did not use. [Laughter.]

The CHAIRMAN. I think if I needed a lawyer in Chicago, I would know where to go.

Senator Dole, you have an amendment on the floor and you have been able to stay longer than you wish to. Would you like to pick this up?

Senator DOLE. I had not heard that before, that if you practice defensive medicine that it is malpractice. Is that what you suggest?

Dr. CORBOY. I use that kind of classic term, yes, sir. I believe that defensive medicine is malpractice. If it is not needed, why do it?

Senator DOLE. So you would not do anything on a Federal level. But if we do something anyway, what would you suggest, even though you would not recommend it?

Dr. CORBOY. On defensive medicine?

Senator DOLE. No, on the whole issue of malpractice reform.

Dr. CORBOY. Well, I would respectfully suggest that the States be allowed to handle their own problems.

Senator DOLE. But we may not agree with that. We may do something. If we did something, what would be your recommendation?

Dr. CORBOY. In the tort system?

Senator DOLE. Yes.

Dr. CORBOY. Well, my recommendation, again, I respectfully suggest just leave it alone. I do not think you need it. I do not think the 55 States, territories and Districts need federalization of the tort system. The States are doing a fairly good job of it now. Those that have rejected caps have rejected caps for a variety of reasons.

In my State caps have been declared unconstitutional. Other States have determined that caps are constitutional. California, by the way, and Massachusetts, have caps. But the cost of per capita personal medical care, even though they have caps in those two States, has not only appreciably increased, it has doubled.

There is no relationship between putting caps on damages and having medical care reduced.

Senator DOLE. Did you happen to watch, I think about a year ago, 60 Minutes had a piece on physicians who had left the practice of medicine. One opened a pet store and they did a variety of things just to get away from these what are termed depressive, devastating lawsuits. Did you happen to see that?

Dr. CORBOY. No, sir. But if the lawsuits were devastating, it means that the people were very, very badly hurt.

I do not know of any doctor who has left the profession. There may be some, I do not know of any doctor—and keep in mind, this is the kind of work I do day in and day out. That does not mean that other lawyers in the ABA do not disagree with me. I just happen to be one vote in the committee that came with these results. Perhaps I was more persuasive than others, but I only had one vote.

But in any event, I do not know of one doctor, certainly in my community, that has been forced out of the practice of medicine because of a malpractice lawsuit. Lawyers do not go after personal assets of doctors. They go after the assets of the insurance company that charges a premium to defend the doctor and to supply the doctor with a defense.

Senator DOLE. I think it was based on the increase in the premium. But that may or may not be the case.

I would like to ask Dr. Cleaveland to respond. I do not want to get into a big argument here between a doctor and a lawyer.

The CHAIRMAN. You got it right in the middle there, a doctor and a lawyer.

Senator DOLE. I know. Dr. Niles, Dr. Cleaveland.

Dr. CLEAVELAND. I really am somewhat offended that defensive medicine and malpractice are equated. Defensive medicine is occasioned by the almost weekly reporting in my State of suits seeking $20 to $35 million of damages against a physician.

Many of those suits play out and nothing ever happens, no action is ever finalized, no money ever changes hands, except the substantial cost involved in defense.

The public is never informed of those outcomes. It is the reminder each month of staggering amounts of money, far, far beyond the assets of physicians, far beyond the limits of their malpractice coverage. One of the realities is the implied or the overt threat of patients that if you do not deliver a certain service I will take you to court.

A few nights in the grocery store, a patient I had examined earlier that day said, my hurt hip, you did not examine it. We had better do it. I would hate to see you in court. Now that is while I am minding my own business and shopping for milk and potato chips—low sodium potato chips. That threat is a constant cloud that is out there that we must deal with.

The public expectation for use of technology is absolutely staggering. The appetite for the latest and the most expensive knows no bounds. The media cover the medical miracles. They never tell you about the cost, nor do they tell you about the risk.

So we are serving as a constant arbiter between the resources of the insurer, whether it is Medicare or the private insurer, between our judgment, between our patient demands. But all of it is played out against this backdrop of malpractice is here to get you.

Senator DOLE. Dr. Niles?

Dr. NILES. Yes, I wanted to comment on four points that the attorney made. His issue about the fact that obstetricians are sustaining the same, there are 25,000 at list.

In the material that we have submitted with our testimony there is a report that was completed in June of 1990 by the Southern Legislative Conference. They state, and I will read directly from it, "Many OB/GYNs are dropping obstetrics from their practice. In 1982 80 percent of the OB/GYNs in the south atlantic States and 93 percent of the OB/GYNs in the east, south central States practice obstetrics." By 1989 these percentages had dropped to 72 percent and 86 percent respectively and this was in 1990.

This is documented. I can tell you that a number of physicians, even though they are listed as obstetricians and gynecologists, do not continue to practice obstetrics. It is a phenomenon that happens with age. As you get older usually you stop doing. But what we are seeing is physicians stop practicing obstetrics a lot earlier because of the cost of premiums and many times their families are completed or their children are finished school and they just do not need that additional income and headache.

The other thing that really bothered me, and I do not have to say this, is the comment that the attorney made with his comment

about States with their local customs. That reminds me of the civil rights era when the excuse given for not passing civil rights legislation continued segregation in the south was, these were our local customs and they should be honored. I think that is offensive.

The next thing is that the $25,000 cap, I think testimony has already been given by someone not from the medical field, has indicated that the cap on non-economic loss does make a difference in the cost of premiums and the cost of insurance.

The problem that we had with the cap is that it is for non-economic losses. Nowhere in our legislation or proposed legislation that I have ever seen is there any suggestion that if there are damages those damages would not be honored. If it was for a cost for injury, loss of work, et cetera, but the pain and suffering concept of non-economic loss needs to have that cap for two reasons.

One is that that value, that number that is given is arbitrary. It is a jury's view of the situation. And honestly a cerebral palsy case that is a very sympathetic type of situation. Fifty percent of many of these claims that you see in these large judgments are based upon that pain and suffering provision.

Unfortunately, this is unpredictable in terms of number of cases, how this is going to occur. If you have a cap, there is some predictability. The actuaries' insurance company can make that determination.

What is also interesting is that the trial attorney shares in that pain and suffering. They get one-third or whatever of that pain and suffering just as well. If that was all going to the injured party, that would be one thing. I think they are only protecting their own cottage industry with these comments.

Senator DOLE. My time has expired. I just want the record to reflect, no one is suggesting that someone who is negligent should not be held responsible. I think that that is given.

Dr. NILES. Absolutely not.

Senator DOLE. I see our colleague is here, Senator Metzenbaum. So I will not continue this. But I think there is a tension between trial lawyers and physicians. I have noticed it as I have traveled around the country.

Senator CHAFEE. That is really an acute observation.

Senator DOLE. Yes. [Laughter.]

Dr. CORBOY. Is acute one word, sir, or two?

Senator DOLE. I do not know where you go for your medical treatment, but I wish you the best. [Laughter.]

The CHAIRMAN. We have just a moment because Senator Metzenbaum has been waiting patiently. I am going to take the liberty of asking Dr. Brennan who is an M.D. and a J.D., would you have any counsel for us in the terms of exchange you have just heard?

Dr. BRENNAN. Two things I would say. First of all, defensive medicine is very difficult to define, because what is happening is something at the margin. You talk about doing more high technology tests. Patients want them; doctors get paid more if they do them. Doctors are probably a little bit safer if they do them. So it is difficult to disentangle what is the main motivation.

But at the margin, we do see this defensive medicine effect. I do not want to tell Mr. Corboy his business, but when we teach torts at law school we usually think about three different things—injury,

causation and negligence. There is a lot of inappropriate medical care out there. Part of it is due to defensive medicine, but inappropriate care is not actionable under the tort law unless there is an injury. So we need to disentangle defensive medicine from medical malpractice.

I would make one other point, which is about the sort of inequities that characterize the malpractice system. Research definitely demonstrates that patients who are poor are very unlikely to sue. Patients at the poverty line are one-tenth as likely to sue as patients who make more than $40,000 a year. So this is a very inequitable system.

Unfortunately, the sorts of reforms that are being proposed will just make it more inequitable because the contingency fee is the one thing that keeps the poor patient in the play; and if you decrease the contingency fee, you decrease their ability to sue.

The CHAIRMAN. That is a very clear answer and a dilemma indeed.

Senator Hatch?

Senator HATCH. I am very interested in this as you can all tell. Ms. Corrigan, your particular studies only consider direct costs. They do not consider the costs of defensive medicine.

Dr. CORRIGAN. That is correct.

Senator HATCH. But you are going to continue to study this?

Dr. CORRIGAN. The final report will be out in the summer.

Senator HATCH. We have not defined this very well. You know, the AMA indicates that there might be a $30 billion defensive medicine cost to society this next year, at least that is my recollection. It was $25 billion last year.

If the AMA admits to $30 billion in unnecessary defensive medicine, then you have to ask yourselves how much must it really be. I have heard estimates anywhere up from $100 billion a year.

That trend started in the 1960's, I guess, or late 1950's when the doctrine of informed consent was overruled. I think it was in Pennsylvania.

Up until that time, the standard of practice in the community was the basic standard. But when that was overruled, then the advice of all defense lawyers with regard to medical liability became that you had better do everything possible to have everything in your history. If you do get sued because of a bad result, even though you have done everything scientifically possible to try and have a good result, then you at least have that history that will show you have tried everything.

And, consequently, now doctors are overdoing an awful lot of procedures that are not totally necessary. It is like Dr. Cleaveland has indicated, you could be criticized for not having conducted every one of those procedures if you did not have them all documented in your history. Right?

Dr. CLEAVELAND. That is correct.

Senator HATCH. And if you did get into a situation where a bad result occurred, not because of any fault of yours, but just because medical science is not an exact science, you would find yourself attacked if you had not done any one of those things, right?

Dr. CLEAVELAND. That is correct, yes.

Senator HATCH. Now I have a lot of regard for Phil Corboy. I think he is one of the finest trial lawyers in the country and certainly one of the best plaintiffs' lawyers in the country. We have been friends for a number of years. I recognize his viewpoint.

The plaintiffs' trial lawyers play a very significant role; they help to weed out people who are not good in the medical profession, people who should not be doing surgery, people who might not be proficient doctors. That is a very good consumer alternative from time to time.

On the other hand, I do not think anybody denies it has gone way too far. I have chatted with Dr. Niles and we agree—and, Phil, you need to know this—there are sections of this country where you cannot find an obstetrician/gynecologist to deliver children. They just will not do it because of the liability and the high cost of medical liability insurance approaching $85,000 and $90,000 a year.

You have to deliver an awful lot more babies than they can deliver to be able to pay that for insurance, plus office expenses and make a halfway decent living. So a lot of them are going out of the profession. A lot of gynecologists refuse to deliver babies today and limit their practice to gynecology.

So there has to be a happy medium here. What I am concerned about with 900 medical malpractice lawsuits filed today, the average settlement $300,000 to $500,000, something has to be done.

We all know that juries do "run away." They tend not to feel empathy for the doctor as much as they do for the patient who has the bad result. That is why the theory of caps has come into being.

This is basically a general question to all of you—if we go to a full-blown medical liability approach similar to that in Senator Chafee's bill or any other number of bills here and we do everything we can to enact it. Do you agree with my contention that there would not be much cost savings in the first year or so? But it would lead us to standards of practice in the community, the meaning of which would alleviate liability, that would over the long run save billions of dollars.

That is something I absolutely know is true. Now the question is whether we want to do that, whether we should adopt the position of Mr. Corboy who says leave it alone, let the States handle it and they are going to do this if we do not do it in an effective way. Or should we do something about it from a Federal standpoint since the Federal Government is paying a very, very high share of the cost of medical care, a good percentage of which costs goes for medical liability insurance, which in some cases cannot even be obtained.

So who disagrees with my observations? I would like to start with you Dr. Niles.

Dr. NILES. I would not disagree with your observation. But I would also like to suggest in the testimony that we did supply a graph that demonstrated how the affect of caps in the California legislation has contained——

Senator HATCH. Brought down the costs.

Dr. NILES.—health care costs, malpractice costs. It has not reduced it. It has contained it. Compared to the District of Columbia——

Senator HATCH. If it has contained it, it has brought them down.

Dr. NILES. It continued to rise in the District of Columbia because we do not have any caps.

Senator HATCH. Right.

Dr. NILES. So there is enough data to support that it will contain the costs and it would be significant if we did have caps.

Senator HATCH. All right.

Dr. NILES. And I do not believe the individual States—and I will speak for the District of Columbia, our City Council, has three trial lawyers that are members of the Council, and it is unlikely that we would ever have any tort reform in the District of Columbia.

Senator HATCH. We will go right across. Ms. Corrigan, Dr. Cleaveland, Dr. Brennan.

Dr. CORRIGAN. Senator Hatch, I am only confused about where the savings are going to come from in the long run.

Senator HATCH. My point is that I believe it would lead to standards of practice, the meaning of which would alleviate liability.

Dr. CORRIGAN. In other words, reductions in defensive medicine?

Senator HATCH. Right. Because then the standards of practice would say, he does not have to do every one of those procedures. In fact, this may be the best procedure under this set of circumstances. By doing that you would count out two or three procedures.

For instance, if a person gets in an automobile accident, gets hit from behind, and he or she has a muscle strain. The treatment used to be to provide muscle relaxants, and tell the patient to get bed rest, come back in a couple of weeks, if it has not helped you, we will go further.

Now if the patient walks in, in many cases, there is an immediate CT scan. If that does not work, then an MRI and then the tests go on from there. By the time the patient gets through, what used to cost $20 is now $2,000 and $3,000, just like you described in your cardiovascular example.

Dr. CORRIGAN. I would like just to make two comments. First, there is no good evidence so far about the cost of defensive medicine.

Senator HATCH. That is because nobody has really gotten into it.

Dr. CORRIGAN. Yes. And there is no evidence yet on the link between malpractice reform and physicians' clinical practices. Those are two questions that I cannot address any further today.

Senator HATCH. All right.

Dr. CLEAVELAND. Senator Hatch, I am afraid that unfortunately our present malpractice system does not weed out incompetence. In fact, the settlements in the cases in my State seem to bear no relationship to identifying such individuals.

Only when we have a quality assurance system that empowers among others the physicians to help police quality of care do we solve this. I want to see us save dollars and lives and reduce our undue reliance on a very expensive, and sometimes hazardous technology.

In my State, for instance, it would be logical that the State Licensure Board should be able to lift the licenses or suspend licenses of physicians who do not practice well. Their attempts to do so are

often tied up in the courts because it is seen as a mechanism of depriving a physician of a livelihood. So we have a log jam there.

If practices are profiled regionally and we identify the outliers, the physicians who do not have a predicted outcome according to guidelines, then we can seek to intervene with education and expose that person to upgrades in their medical background.

I would like to see us get to prevention. The present system does nothing to prevent unfortunate outcomes in medical therapy. Education will. A nationally applied quality assurance program will. That is the goal toward which we all must work.

Senator HATCH. Dr. Brennan.

Dr. BRENNAN. Well, I think we are missing an opportunity here because basically premiums are around $10 billion and the range of estimates for undefensive medicine is $10 to $20 billion. So that is $30 billion. Now the costs——

Senator HATCH. That is if you accept those figures. There are a lot of people who do not accept them.

Dr. BRENNAN. There are a lot of people who do not.

Senator HATCH. Who pay the bills.

Dr. BRENNAN. But just to give you a sense of the sort of validity of those, former-Vice President Quayle says it is $15 billion. So there are a lot of people who are within that range.

Senator HATCH. I would not cite him as an authority. However, I have to talk in terms of trial lawyers and doctors who have really studied this and people at HHS and elsewhere who have estimated it is well over $100 billion.

Dr. BRENNAN. In any case, we know that the costs of medical injuries themselves is somewhere around $60 billion today. So those estimates are much higher than the estimates of the premiums and the costs of defensive medicines. I want to agree with Dr. Cleaveland: that the critical thing has to be prevention. You are not going to get prevention out of the present system; and you are not going to get prevention out of the reforms that are proposed.

You need to think about other methods for going about addressing medical injuries. Because the doctors hate the system so much that the signals that the tort system sends are never heard. So they were not getting the kind of deterrence out of the tort system that we should.

Senator HATCH. What about pushing toward the standards of practice in the respective medical professions, would that lead to more deterrence, more peer review, more prevention?

Dr. BRENNAN. I think that is very important, but I do not think that is going to come through the malpractice track. I think what you have to do is think about what you are going to do about the medical injuries that are occurring today.

We are silently absorbing the costs of most medical injuries, the overwhelming majority of which are preventable. But physicians are afraid to undertake these prevention strategies because of the warfare between doctors and lawyers and medical malpractice.

Dr. NILES. Senator, I think the study that has been done in Maine where they are using guidelines in relation to their insurance situation could be—and they are doing a pilot study on that and that information using guidelines. I personally believe that at our hospital we have already instituted guidelines. I think that

what you have already said is, if there are a set number of parameters that the doctor follows, he follows those things, then he will feel more comfortable that he has followed those things and will not add additional layers if the community can then determine within that facility what they want to do.

That certainly would be helpful. If that wants to be included as part of the package with prevention as a suggestion these guidelines be formed, I believe a physician would accept that.

Senator HATCH. I am sorry to take so long. Mr. Corboy?

The CHAIRMAN. Mr. Corboy, you have the final rebuttal.

Dr. CORBOY. Thank you. Let me take 30 seconds of Senator Metzenbaum's time. I do this for a living—13 percent of my practice is devoted to malpractice; 87 percent of it is airplanes, railroads, FELA work, et cetera.

There is a reason why the percentage is small. Most doctors are not negligent. Also the costs of litigation, not attorneys fees, is quite high. So I agree there are a lot of cases that never reach the courts. But be that as it may, the only way to test the cost of medical malpractice litigation is to look at the premiums.

We are not talking about anything other than the premiums that medical providers spend in the defense and in the delineation of the responsibilities to the courts. Less than 1 percent—if it is $9 million I think you are pretty correct—three-quarters of 1 percent of the costs of medical care in this country is in the form of medical malpractice premiums.

Now that results, by the way, and I think we may have lost something in this whole area of discussion this morning, today under this haphazard system, under this intemperate system, under the system which nobody is happy with, the doctors and the hospitals are winning two-thirds of the cases in which they go to trial.

From 65 to 75 percent of the cases the juries turn them away. They are not held responsible.

Senator HATCH. With good reason.

Dr. CORBOY. Pardon, sir?

Senator HATCH. With good reason in many cases. With good reason.

Dr. CORBOY. There is no negligence.

Senator HATCH. That is right.

Dr. CORBOY. We have to have some assumption the juries know what they are doing.

Senator HATCH. That is right.

Dr. CORBOY. So they find the doctors not negligent in two out of three cases. Now would it be nice if they found them on 90 percent not negligent? Of course. But this is not a perfect world. I do not know why doctors, nor lawyers, should get any preferential treatment in the courthouse.

By the way, I do not understand—I am completely uninformed—as to the language, a $20 million lawsuit. There are no lawsuits in 38 States of the country which are allowed to state the addendum. In 38 States in the country, when a negligence, malpractice lawsuit is filed they are not allowed to ask for a specific sum of money. That is up to a jury.

Dr. NILES. I do not know where you come from, sir. That is what is in the pleadings. I have seen them all the time.

Dr. CORBOY. They cannot put it in the pleadings.

Dr. NILES. Well, it is in there.

Senator HATCH. He is talking about in D.C.

Dr. NILES. It is in there.

Dr. CORBOY. Well, then the lawyer should be disbarred.

The CHAIRMAN. Doctors, gentlemen, we have another panel, we have another Senator.

Now, Senator Chafee, you are next, then Senator Grassley.

Senator CHAFEE. I thought I was here first.

The CHAIRMAN. Senator Grassley, you were here second. Forgive me.

Senator GRASSLEY. Yes. So far we have not made any mention of what the President's health care plan does in this area. I kind of wish we would have had a witness from the administration to come up here and defend that program.

I do not know whether any of you were on President Clinton's secret health care task force or not. But if you were then you can really fill us in because I would like to know what went on there. But I am interested in the views that any of you might have on that specific plan in regard to three areas—one, the collateral source rule; the limit on attorneys fees; and the requirement for exhausting ADR before you get into court.

So I would ask any or all who want to comment on any of those three areas to do it, not in too great a length, but I would like to have your view.

Dr. CORBOY. I can start out, Senator. As far as ADR is concerned, the American Bar Association is 100 percent in favor of ADR. There is absolutely nothing wrong, as a matter of fact it is beneficial.

In Detroit, Michigan they have mandatory ADR in every case. In Detroit, Michigan the cases get to trial in a year-and-a-half. In Illinois, we do not have mandatory of any type. We, too, have ADR, but not mandatory. It takes 3 years in Illinois. I respectfully suggest and make the finding, if I am allowed to, that ADR will weed out cases that should not go to trial. We all know that in every large community in the country, 5 percent of the cases that are tried are the maximum that go to trial. The rest are all settled or disposed of on the pleadings.

So we will improve the system by getting those 5 percent to trial in the courts if as we believe in the ABA, some type of ADR is imposed upon the system, and that it will help weed out those cases that are going to be settled or dismissed for legal reasons long before getting there.

Now you can have mandatory ADR but it cannot be binding because we have a constitutional provision of a right to trial by jury. So if we are talking about ADR, I also do not believe it should be before trial. Why? Because if it is before trial, it is one more level that has to be utilized and has to be dissipated before getting to the court system.

I think the best way to handle ADR is to have it after suit is filed, and to have a mandatory ADR before going to trial. It will

weed out hopefully those cases with reference to those that would be settled.

Concerning a limit on attorneys fees, many States have had that already. In the State I live in, fees are as follows in medical malpractice cases. It is one-third of the first $150,000. It is 25 percent between $150,000 and $1 million and it is 20 percent if over $1 million. If the Congress of the United States sees fit to have attorneys fees at one-third and preempts the States, I would hazard that most lawyers will not complain about it.

I think I have to be very blunt with you, most malpractice lawyers do not charge a third. It just does not happen. The marketplace takes care of it. Long before there was a mandatory attorneys fees aspect in our legislation, we were charging less on larger cases because that is what the traffic requires.

With references to the collateral source rule, we have mixed feelings about that because I am not so sure what is going to happen if there is universal medical care. If everybody has got medical insurance, I do not know what it means. My guess is that what it would mean is there will be subrogation rights. If you have subrogation rights, you do not need a collateral source rule.

Why? Because the insurance company is going to get paid back out of the corpus it has created either by a settlement or a satisfactional judgment.

If you have a plain, ordinary collateral source rule, however, I see some problems. An insurance company has accepted premiums. They have paid on those premiums. They have accepted premiums all those years. In many cases, it is part of the union contract. In other cases, it is a voluntary contribution made by a potential victim, whether it is an automobile case or whether it is a product liability case, whether it is an airplane case or a railroad case or whether it is in medical malpractice.

I think it is a little bit unfair to just plain say that a person who has a collateral source should have that collateral source admitted into evidence to diminish his damages.

Carrying it to extreme, if my rich uncle, which I do not have, decides to pay my medical expenses, that is a collateral source. I do not know why an insurance company should have the benefit of that collateral source.

Senator GRASSLEY. Dr. Niles, particularly.

Dr. NILES. You were asking the question specifically about the Clinton bill. There is no provision for standard liability. There is no provision for reversion of joint and several liability. There is no provision or statute of limitation for minors. There is no provision or statute of limitation for adults. There is no provision for punitive damages. There is no provision for capping on non-economic damages.

There is the practice guidelines which we mentioned earlier that is suggested and very easily supported. The problem with the ADR, however, is that sometime if this is not mandatory then you are just spinning your wheels. You go to ADR and then you wind up going to court anyway.

Then also the comment about lawyers only make one-third or less, and included in our testimony we included a Forbes magazine

article in 1989 which also lists the total income of this particular witness——

The CHAIRMAN. Which we will put in the record.

Dr. NILES. As well as the fact that it indicates that the patients do not receive—they receive less than almost a third of what the total judgment is, rather than the lawyer receiving one-third it is the reverse.

The CHAIRMAN. Out of concern for our courtesy for our colleague, Senator Metzenbaum, I am just going to have to regretfully rule that the last questioner is Senator Chafee.

Senator CHAFEE. Thank you very much. I am going to ask you a couple of questions. I would appreciate it if you would keep your remarks and answers brief. Perhaps yes or no, no maybes if possible.

The questions are as follows. First, I want to say regarding Dr. Corboy, he who pays the piper has the right to call the tune. The U.S. Government is paying a very, very substantial part of the health care cost in this country, so I think the Congress of the United States has the right to have some say in this whole subject.

I appreciate the points you have made about complexities of getting the Federal courts into it, but those points are something we will have to wrestle with and I think it is good that you brought them to our attention.

In our legislation, the one I am associated with, we have alternative dispute resolution required. We further have in our legislation that if you appeal from the ADR to the courts as you, Dr. Corboy point out, you have a right to under the Constitution to appeal and the courts give you less than the ADR did, then you have to pay the other side's attorneys fees. I think Dr. Cleaveland called this the English rule.

My question is: What do you think of that? Briefly if you would. In other words, you can appeal, that is your right. If you get less in the court—this is obviously to cut off frivolous appeals—instead of giving you a whole new run at the game, if you get less from the courts that the ADR gave you, you, the appellant, have to pay the other side's attorneys cost. Why is that not fair?

Dr. CORBOY. I suppose the most magnificent example of that would be where the plaintiff got nothing. He appealed or went to jury and got nothing.

Senator CHAFEE. Right.

Dr. CORBOY. I suggest that nothing happens, because people who are horribly injured and lose their cases do not have any money to pay the costs of the other side. It just does not happen. That is why there is no English rule in this country.

Senator CHAFEE. No, but here the reason we usually do not have an English rule, as you know, is you cannot get a shot. But in my example you have gotten a shot, you have gotten a shot through the alternative dispute resolution process. The arbitrator there, who obviously is selected by both sides or however the system works, says this is a case without merit. So you get nothing.

So you don't like that?

Dr. CORBOY. Oh, no, I am not antagonistic at all if the ADR is subsequent to filing lawsuits so it does not interfere with the trial on time.

Senator CHAFEE. Oh, no. We are not trying to cut off the rights to the courts.

Dr. CORBOY. So let us assume that happens and the plaintiff gets less. I have no problem if there is an ADR system of having the plaintiff in some way or another penalized.

By the same token, if the defendant is hit for more than he has offered or hit for more than the alternative dispute resolution supplies—let us assume the alternative resolution supplies $100,000 award. And the defendant does not pay it, he appeals or she or it. And there is a $200,000 verdict. Should not there be a penalty to make——

Senator CHAFEE. Absolutely.

Dr. CORBOY. Fine. I have no objection. I have one answer to that whole thing——

Senator CHAFEE. The clock is ticking here.

Dr. CORBOY. The answer is called prejudgment interest.

Senator CHAFEE. That is too complicated for me. What is the next one?

Dr. BRENNAN. Mandatory non-binding arbitration is useless. It only increases attorneys fees. That is why Dr. Corboy can accommodate it. If you put this modified English rule in place it will give the ADR some teeth and it will be at least an interesting trial.

Senator CHAFEE. Dr. Cleaveland, you said you were for it?

Dr. CLEAVELAND. Yes.

Senator CHAFEE. Thank you. Ms. Corrigan?

Dr. CORRIGAN. I think as long as the ADR was a fair process. But I think it is important to keep it——

Senator CHAFEE. Well, we can hardly describe our program as an unfair process. [Laughter.]

Dr. Niles.

Dr. NILES. Yes, I would support it.

Senator CHAFEE. Thank you very much. Next. Under our program we say there are punitive damages, but only half of the punitive damages go to the plaintiff. The other half goes to where you all say you want to see something happen, and that is that it goes to the State for a retraining program for doctors so we will not have doctors making these errors.

Dr. Corboy, what do you think of it?

Dr. CORBOY. In our State, Senator——

Senator CHAFEE. No, just what do you think of it.

Dr. CORBOY. I think it is a good idea because that is the law in Illinois.

Senator CHAFEE. All right. That is the law now in Illinois?

Dr. CORBOY. Yes, sir, only not the figure of 50 percent. A portion goes to the State Rehabilitation Department.

Senator CHAFEE. All right. How about the portion that does not go to the State Rehabilitation?

Dr. CORBOY. I wanted to say something else, but you would not let me. We do not have punitive damages in Illinois for doctors. You cannot sue a doctor in Illinois for punitive damages.

The CHAIRMAN. Hurry. Dr. Brennan?

Dr. BRENNAN. It is a very good compromise on the punitive damage question.

Dr. CLEAVELAND. It is a strong compromise. If later there is one minute I would like to tell you about an experiment in Tennessee.

Senator CHAFEE. There is not. I am sorry, there is not.

The CHAIRMAN. For the record, send it in.

Senator CHAFEE. Ms. Corrigan?

Dr. CORRIGAN. Punitive damages are not a large problem, but I guess it is a good way of dealing with this.

Dr. NILES. Yes.

Senator CHAFEE. Thank you. I would just like to say this in answer to one of the points here. I think Dr. Cleaveland will back me up. The statistics may show that many of the suits against doctors do not succeed as you were pointing out, Mr. Corboy, but I do not think that brings up the anguish that a doctor or any defendant goes through when a suit is brought. And I do not think it is adequate to say, oh, a lot of these suits are frivolous and do not end up with any payment anyway.

Every doctor I have talked to says it is a horrible experience to go through. I just do not think we ought to casually dismiss that point and go on statistics that show only why X percent of the result and the judgment against the doctor.

Dr. NILES. And many of them are settled before they get to trial.

Senator CHAFEE. Many of them are settled. But the grief and the pain and the difficulties for the defendant—and it is not just doctors that are a defendant—any defendant finds this very——

Dr. CORBOY. I was going to suggest that. I have been sued and I did not like it.

Senator CHAFEE. No, nobody likes it.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Chafee. Now we have to contemplate the fact that after two centuries of freedom we are reverting to English rule. Senator Conrad wants a last question.

Senator CONRAD. Yes, thank you, Mr. Chairman.

Dr. Brennan, you testified that in the cases that you have looked at 80 percent had no adverse medical event or negligence. I think most Americans would say they clearly want to have a right to sue in cases where they have been injured, in cases where there is negligence. But again, your finding is that in 80 percent of the cases you looked at there was no adverse medical event or negligence.

My question would be, my understanding is, in Canada there is a higher threshold to be able to file a suit, that is a higher threshold you have to get over in order to initiate a legal action. Are you familiar with that circumstance?

Dr. BRENNAN. No, I am not, not that particular circumstance.

Senator CONRAD. Dr. Corboy, are you familiar with it?

Mr. CORBOY. No, sir, I am not. It sounds like a little of the Keaton O'Connell's original no-fault law in automobile cases, where you had X number of dollars before—a threshold system.

Senator CONRAD. No, it is not an economic threshold as I understand it. I understand in Canada there has to be a finding that there was actual negligence.

Dr. BRENNAN. They clearly have a higher threshold with the standard of care, with the deviation from the standard of care before a suit gets into court. As a result, they have much lower levels of malpractice litigation.

Senator CONRAD. So you are familiar with that system?

Dr. BRENNAN. I am familiar with the Canadian system, but I do not this particular doctrinal language which sets that out.

Senator CONRAD. Could you tell me what your reaction is to that system?

Dr. BRENNAN. Well, there is less malpractice litigation. The problem with the malpractice system is it is bad on both ends. We have a lot of cases that are leading to claims in which the doctors did not do anything wrong. And yet in the cases where the patient is injured and should have some compensation many times that patient does not bring a suit or cannot bring a suit.

So it is hard for me to advocate on the one hand let us put restrictions in place because so many suits are frivolous, because on the other hand you have lots of people who are due compensation who are not getting it. So it would be difficult to say this is an important reform, because I realize that in addition to the 80 percent of frivolous cases, only 3 percent of the negligent injuries are leading to litigation.

So we need a different kind of system that gets patients into a compensation mechanism, that does not require this device of fight between the doctor and the patient.

Senator CONRAD. I thank the Chairman. I thank the panel.

The CHAIRMAN. I thank Senator Conrad.

I was going to ask Dr. Niles if he remembers a word of my commencement address at his medical school. [Laughter.]

But I do not think I will take that risk.

Dr. NILES. You were a prophet and what you said has come to pass about the family. Yes, I do remember your speech.

The CHAIRMAN. You do. Thank you all very much. We have learned a lot and we thank you all particularly for the data you have brought. We are going to legislate. I hope we do well. We are going to be asking you, if anybody wants to send us something in writing after this, a point you did not make, or you know tomorrow morning you say, oh, I wish I had said, will you just please do.

Again, thank you very much. You could not be more open and helpful. Dr. Corboy, I am sure you are welcome in any hospital.

Dr. CORBOY. I have a son a neurologist.

The CHAIRMAN. There you are. Good for you all.

Our next panel concerns antitrust issues. We welcome you, Senator. We are very much aware that we had to keep you waiting. But I am sure you were as interested in the exchanges as we were.

STATEMENT OF HON. HOWARD M. METZENBAUM, A U.S. SENATOR FROM OHIO

Senator METZENBAUM. Thank you very much, Mr. Chairman and members of the committee. I want to say I, indeed did come over to testify before, but I have been told that Senator Harkin was going to precede me and I thought I had that lag time. Then I think something happened on that.

The CHAIRMAN. Right.

Senator METZENBAUM. Be that as it may.

When I appeared before this committee last May a number of members, including Senators Rockefeller, Baucus and Daschle, and I am not sure who the others were, but they told me that hospitals were having difficulty over the antitrust laws.

I indicated that I thought we could resolve those problems without changing the law. I acted on those concerns and 4 months later I am pleased to report that the Justice Department and the Federal Trade Commission published guidelines addressing the hospitals most pressing questions.

I am also pleased to say that the American Hospital Association thanked me publicly for my leadership on that issue.

The CHAIRMAN. Well, good for you.

Senator METZENBAUM. Let me say, Mr. Chairman, that we make a little headway once in awhile.

The CHAIRMAN. Every so often. You cannot lose them all you mean.

Senator METZENBAUM. But having said that, let me add a little bit of discord in this meeting—not brockus discord or raw discord, but I want to say to the Chairman very respectfully that I really do not believe that appropriate jurisdiction for both malpractice and the antitrust issues belong in the Judiciary Committee.

The CHAIRMAN. Yes, sir.

Senator METZENBAUM. And I think that is where they ought to be. I am going to discuss it further with the Chairman, and with the Parliamentarian. I do not think the Chairman has been seeking this jurisdiction. I think it sort of just dropped in his lap and he is just moving forward and doing what chairmen do under the circumstances.

Anyhow, whether it is in this committee or another committee, the Senate is preparing to meet the challenge of health reform. I know that firsthand that our health care system is a mess. Fixing it will not be easy. I think, however, we could make the situation even worse for consumers if we relax our antitrust laws for doctors or hospitals.

For that reason, I am opposed to the antitrust exemptions in the administration's reform bill and the bill sponsored by Senator Chafee. Although the exemptions in the bill differ, both would permit doctors and other providers to fix prices and boycott patients.

I might say parenthetically that in Canada, in Sankechawan when they first put the Canadian plan into effect, all of the doctors in Sankechawan boycotted and said they would not make their services available. That subsequently changed and now I have spoken with the leader of that boycott and he says they are very happy with the Canadian system. But that is not the issue before us today.

The exemption in the Health Security Act gives doctors and other providers blanket antitrust immunity to collude on prices and then negotiate those prices in order to develop a payment schedule. Although the exemption might appear limited, I believe that it will increase the cost of health care for consumers under both fee-for-service, managed care plans and any other kind of plan.

I am not alone in this view. An extraordinary coalition of groups, including the American Association of Retired Persons, the

Consumer Federation of America, speaking now for those who are the beneficiaries of the program, the American Nurses Association, the Federation of American Health Systems, the Group Health Association of America and the major health insurance companies are also opposing those exemptions. And the total list of that group is to be found in my testimony. I think there are probably 20 different organizations—a very broad—based group.

Frankly, I do not believe there is one other health issue on which all of these groups could agree except antitrust. These are not just consumer groups. These are groups from part of the industry. I will submit their letter for the record, Mr. Chairman.

The CHAIRMAN. Yes, sir.

[The letter appears in the appendix.]

Senator METZENBAUM. The only sector of the health care industry that is not represented on the letter are the doctors. That is because the AMA has made winning antitrust concessions its number one legislative priority and has indicated by the full page ad in today's Washington Post, what they are so afraid of. It is directed to the big five insurance companies. But I tell you that it goes far beyond the big five insurance companies to the consumers of this country.

The so-called antitrust relief that the AMA is asking for may sound modest. It is not. To quote an April 11 U.S. News and World Report Article, "The changes that the AMA seeks sound like legal minutia but they represent major departures from current antitrust laws." I urge this committee to reject them whether or not this committee has the jurisdiction.

Make no mistake——

The CHAIRMAN. That is a beautiful case. I believe attorneys refer to that as arguing in the alternative. [Laughter.]

First of all you do not have jurisdiction; second, if you do have jurisdiction you should reject it.

Senator METZENBAUM. Make no mistake, allowing doctors, hospitals or other providers to collude and fix prices is bad medicine for consumers. Although the hospitals do not favor exemptions, let me give you an example of how collusion can raise prices.

Independence Blue Cross of Philadelphia told the Antitrust Division that its costs were $57 million higher when the State required it to negotiate prices with a large group of hospitals. The company estimated that in 5 years it would save over $500 million from individual negotiations.

The antitrust exemptions in Senator Chafee's bill would also raise prices for consumers. The coalition I just described has opposed the Chafee exemptions and their mirror image, S.1658, sponsored by Senators Hatch and Thurmond.

Only yesterday I received a letter from the State Attorney General opposing the exemptions. I ask, Mr. Chairman, that that may be included in the record as well.

The CHAIRMAN. Without objection, of course.

The CHAIRMAN. The Department of Justice has also opposed these exemptions on grounds that they are "unnecessary and potentially harmful." The fact is the Chafee and Hatch exemptions would undermine antitrust enforcement by creating antitrust loopholes for medical cartels, by conferring permanent immunity on

any health care deal that the Justice Department failed to block in 90 days—and that is unrealistic—by requiring the Justice Department to obtain clearance from the Department of Health and Human Services before approving a health care deal—as if the Department of Health and Human Services is not already going to have enough on their plate to take care of—by authorizing costly Federal court appeals by disappointed applicants for antitrust immunity which would certainly cause the government considerably more dollars to fight it, and by reducing antitrust penalties for anticompetitive joint ventures.

My view is that provider cartels are more likely to stall health care reform than vigorous enforcement of the antitrust laws. As I stated previously, if there ever was a problem, the Justice Department and the FDA dealt with it last September. The agencies published guidelines to explain antitrust enforcement to providers and promised a 90-day review of health care deals.

So far, in that short period, 11 deals have been reviewed and none have been challenged. The guidelines have worked well and I intend to urge the agencies to update and expand them. I am confident they will respond.

I would be more willing to consider antitrust relief if providers could show me that those laws block pro—competitive deals that would benefit consumers. Neither I, nor the American people, would support antitrust exemptions that created medical cartels that served no purpose other than to increase prices.

For now, I am convinced that the only change we need to make in the antitrust laws to speed health reform is to revoke the McCarren-Ferguson exemption for health insurance.

That change, which is included in the Health Security Act, would prevent insurance companies from fixing the price and the terms of health care coverage. I again repeat, Mr. Chairman, that I urge your support of the position of the various groups that I have previously mentioned on the whole issue of antitrust exemptions. But beyond that I would hope, Mr. Chairman, that you would facilitate sending this matter over to the Judiciary Committee, as well as the malpractice issue.

Thank you.

The CHAIRMAN. We thank you very much, Senator. This is very emphatic testimony. We congratulate you on that success, the guidelines that have been issued.

Senator Rockefeller, did you have any questions?

Senator ROCKEFELLER. I have two comments, Mr. Chairman. One, I disagree with Senator Metzenbaum—this will not be in the form of a question—on the matter of jurisdiction on malpractice reform. This committee, if it would choose to do so, I think can have some jurisdiction, ought to have some jurisdiction over malpractice reform, tort reform, by virtue of the fact that we pay for so much of medicine and the Judiciary Committee pays for none of it.

My concern is if this goes to the Judiciary Committee, Senator Biden, having shown not a very great interest in this subject or in taking ownership of this subject in any event who is now soon going to be confronted by a new Supreme Court Justice what will, in fact, happen, Chairman Moynihan, is that it will be turned over

to Howell Heflin and to some degree to Senator Metzenbaum. But primarily to Howell Heflin.

What Howell Heflin will do is, he will discharge an extremely weak malpractice package, which will have no modification of collateral source, maybe some form of alternative dispute resolution and maybe some form of the so-called certificate of merit or pretrial screening, which will be wholly inadequate.

So that I would urge the Chairman not to simply abandon this most important matter to a committee where it will be trashed. Secondly, I want to say with respect—since I was not able to talk on malpractice reform—I want to say to those who favor malpractice reform, as the Senator from Ohio understands, I am probably one of the two or three leaders on the democratic side who is in favor or tort reform, and that includes both product liability which I think will pass this year in the Senate and malpractice.

That if those who want it, like the American Medical Association, physicians, Republicans on this committee, and some like myself and others who favor it on this side, let them understand that you are not going to get—there should not be malpractice reform unless we can be certain of universality of coverage and other things which are fundamental to comprehensive health care reform.

There are some people that want malpractice reform so much that indeed they are willing to sacrifice almost anything to get it. I think that would be a very grave error and I think those that want it should show their colors on other aspects of comprehensive health care reform before we get to malpractice reform if it is the desire of this committee to have some hand in that.

Thank you.

The CHAIRMAN. That is a very clear statement.

Senator METZENBAUM. I would just like to respond to my friend from West Virginia.

The CHAIRMAN. Of course, Senator Metzenbaum.

Senator METZENBAUM. I never heard the argument made before that a committee is entitled to jurisdiction and is obligated to take jurisdiction in certain areas should not be meeting its responsibilities because other members of the Senate are not satisfied with the conclusions that that committee might arrive at.

I think that is a very unusual argument. On that basis, I think this Senate could operate in a very unusual way.

Senator ROCKEFELLER. That was one-half of my argument.

Senator METZENBAUM. And with respect to the other half of your argument, I would just say that I would defend to my dying day my friend from West Virginia's right to be wrong. [Laughter.]

Senator ROCKEFELLER. Well, with respect to the other half of my argument, I was trying to lay the issue out exactly as I saw it so that those who in a position to make decisions about this kind of thing could hear it; and, therefore, it was necessary for me to be blunt.

The Judiciary Committee has very little to do with health care. We have everything to do with health care. And we have everything to do with the pay for health care.

Senator METZENBAUM. The financing of health care.

Senator ROCKEFELLER. That is right, financing. The American people pay. But it is not an issue which is not in our, in my judg-

ment, in our jurisdiction. I know that people are particularly anxious to take it on; nobody is particularly anxious to take it on.

The only one who I think is anxious to take it on is Senator Heflin and perhaps the Senator from Ohio. I would be concerned about that, just as I would be concerned about the fact that the Senator from Ohio's sort of blanket rejection of what he said, the Clinton bill's antitrust relief measures to me ignore the fact that doctors and hospitals who are going to be under a tremendous new type of competitive pressure through whatever form of alliances that we put together, and they ought to have the right to get together, provided their share of the market is not more than 20 percent in any given region. They ought to have the right to get together and be able to defend themselves, rather than acting as sole practitioners which they would have to do today.

They have no other resource. I think it is a reasonable compromise.

Senator METZENBAUM. That is no compromise. That is a sell out. I would just say that in this instance I think you are wrong. I think you let the doctors start ganging up and you are going to need to add additional funding in order to have a national health care program in this country.

There is no question about it, that if doctors can collude and work together and negotiate as a group, you will increase the cost of health care in this country. That is the only reason they want to do it. Why else do they want to do it? They want to do it so that they can bargain for higher prices.

I say to you that doctor fees at this moment are certainly high enough in this country without providing a legislative package so that they can force fees up for the American people. I do not think the American people want that.

The CHAIRMAN. Well, can we sort of agree that this exchange will continue in many settings.

Senator METZENBAUM. Thank you.

The CHAIRMAN. Thank you very much, Senator Metzenbaum. You could not be more generous with your time. You were very patient and we are more than appreciative.

Senator METZENBAUM. Thank you for your very many courtesies.

The CHAIRMAN. I have that our next panel will comment on these exchanges. This is our last panel. These hearings have been going on for a year and a quarter now. We have the issue of antitrust legislation. Can we see our witnesses, if they are still here. Come forward.

I see Mary Lou Steptoe, who is Acting Director of the Bureau of Competition of the Federal Trade Commission, and very welcome, indeed. Dr. Richard Corlin who is Vice Speaker of the House of Delegates for the American Medical Association. And Robert Weintraub, Esquire, of Storch & Brenner in New York. And Alphonso O'Neil-White who is Vice President and General Counsel of the Group Health Association of America.

I am going to offer the counsel that a vote will be called in due course and we are going to have to stand in recess when that time comes. But the time has not come and so, Ms. Steptoe, your time has. You are our official witness here, our Federal witness.

Dr. STEPTOE. Do you want me to wait until everyone is sorted out or do you want me to start?

The CHAIRMAN. Sure. Let everybody get a seat. There are enough seats. As a matter of fact, there is a surplus of seats, but do not let that trouble you. Why do not the witnesses cluster. Someone sit next to Ms. Steptoe. Ms. Steptoe, you move in. [Laughter.]

Dr. STEPTOE. I hope there are no implications from that.

The CHAIRMAN. Good. Well done.

Will the witnesses be in order? There we are. Good, you are all seated. All is well. Ms. Steptoe, good afternoon.

STATEMENT OF MARY LOU STEPTOE, J.D., ACTING DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION, WASHINGTON, DC

Ms. STEPTOE. Thank you. I am pleased to be here and give my views and the Commission testimony on the relationship between——

The CHAIRMAN. You are here on behalf of the Federal Trade Commission?

Ms. STEPTOE. Yes, I am here on behalf of the Federal Trade Commission, which has submitted written testimony that I bring with me, and to give you my views following on to that.

The CHAIRMAN. Which will be placed in the record.

[The prepared statement of Ms. Steptoe appears in the appendix.]

Ms. STEPTOE. The topic that I have been assigned is the relationship between antitrust law enforcement and health care markets. I do have to state that I am not here to discuss any particular legislative proposal. The Commission has not been asked to comment and I could not anticipate their views.

But I am here to tell you what the FTC has done and is doing in this area. Our enforcement, I believe, has been instrumental in bringing competition to the health care market. We have opened the doors to alternatives to traditional fee-for-service health care and we have stopped conduct that would result in higher prices or reduced quality and choice of health care service to consumers.

It is my belief, and the Commission's, that continued sound antitrust enforcement will be important to the success of any competition based model for the future health care market. In other words, whatever legislation you do consider, there is no need for an antitrust exemption.

The Commission does not favor one type of health care delivery system over another. Rather, what it does is try to keep markets competitive so that firms can offer and consumers can choose whatever options they prefer. So, to take you back in time, this was the purpose that animated the Commission's challenge 20 years ago to the AMA's ethical restrictions which then prevented doctors from working for a salary paid by an HMO.

Our actions freed physicians to affiliate with managed care plans and opened the door to the significant growth of those plans that we have seen since. More recently, the Commission has stopped a number of boycotts against innovative health care delivery such as multispecialty clinics or nonphysician providers like nurse midwives.

We have enjoined a number of conspiracies against the cost containment efforts of traditional health plans and insurance companies. We have broken up price fixing cartels. And finally, we have also preserved competition among hospitals by a merger review program which prevents transactions that will lead to higher prices or reduced service for consumers.

All this gives you a flavor of what the FTC's presence has meant to the health care industry and the consumers it serves. Many more details are given in the Commission's written testimony.

I hope when you read the chronology of our presence in health care that you will come away with two impressions. The first is, that there is a real need for continuing vigilant antitrust enforcement. There were real problems out there that needed to be stopped and these are problems which could reoccur if the cop on the beat is told to walk away.

Secondly, while we have been vigilant, we have also at the same time not been heavy-handed. Yes, we have stopped boycotts against cost containment, but we have never said that providers cannot collectively provide information and advocate their views on any issue to health care plans. In fact, our orders make that absolutely clear.

Likewise, we have made it clear that professional associations can discipline members who do not meet appropriate quality of care standards or who engage in false, deceptive and other abusive conduct. And as to those hospital mergers, we have reviewed many hundreds of hospital mergers over the past decade and we have challenged exactly 13. We have won all but one of the cases that we have taken to litigation. We are simply not standing in the way of procompetitive hospital mergers. The American Bar Association has said so in a study, and an HHS task force has also said so, specifically noting that antitrust review is not inhibiting rural hospital consolidation.

The same thing is true in hospital joint ventures, which can be anything from sharing laundry services to cooperative buying, to engaging in cooperative efforts to bring medical high tech equipment to a community. We have never challenged a hospital joint venture. And the record simply does not suggest that antitrust has disadvantaged consumers of health care services: quite the contrary. The antitrust agencies have intervened selectively and precisely in instances where competition has been frustrated and consumers are faced with higher prices or undue limitations.

The CHAIRMAN. Ms. Steptoe, you said the antitrust agencies.

Ms. STEPTOE. Well, I really should speak specifically for the Federal Trade Commission, but there is also the Antitrust Division of the Department of Justice.

The CHAIRMAN. The Department of Justice?

Ms. STEPTOE. Yes. And I think my pride in what we have done extends to them, but I do have to be careful about describing their record.

The CHAIRMAN. Fine.

Ms. STEPTOE. Having expressed my pride, let me say that I am not claiming perfection, of course not. If there has been a problem with our record, it has been in the outreach area. There certainly was and still is, though I hope it is diminishing, a perception that

antitrust law is not capable of dealing with the complexities of the health care market.

At the Federal Trade Commission we have always tried to be responsive to industry concerns. Our Health Division lawyers have given advice over the phone and in writing on numerous occasions. I want to point out that advice has never been gone back on. If we tell you over the phone your collaborative effort is no problem from an antitrust perspective, you are not going to see us the next day in court saying, "oh, we changed our mind." That does not happen. You can rely on our advice.

Recently we have stepped up our efforts, as Senator Metzenbaum was telling you. We are mindful that not every health administrator or physician group, particularly those beyond the Beltway, has the Federal Trade Commission number on their rolodex or even in their mind. So we have issued those health policy statements and we have engaged in an ongoing dialogue with members of the industry—doctors, hospitals, nonphysician providers—to find out what more we can do, what else needs to be clarified.

I think that that dynamic, ongoing process, coupled with continued sound antitrust enforcement, is the best guarantee that any competition-based model for a health care market will be successful.

Thank you, sir.

The CHAIRMAN. Thank you. That sounds like a high morale agency. We do not hear that kind of testimony every day.

Dr. Corlin on behalf of the American Medical Association. Good afternoon, sir, and welcome.

STATEMENT OF RICHARD F. CORLIN, M.D., VICE SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION, SANTA MONICA, CA

Dr. CORLIN. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, my name is Richard Corlin. I am a gastroenterologist in Santa Monica, California and Vice Speaker of the American Medical Association House of Delegates. The AMA appreciates this opportunity to address the antitrust environment and its impact on the evolving health care delivery system.

We believe that antitrust law and enforcement activities must be modified as a part of the reform of our health care system. What the AMA is seeking is a clarification of the antitrust laws and not a broad exemption from them. The relief we seek is limited and is designed not to protect fee-for-service or induce boycotts or to reduce competition, but to allow physicians to form integrated networks and to compete with insurance companies where we are prohibited from so competing now.

A number of legislative proposals, including some that are part of the health system reform bills offered by Senators on this committee, would provide the antitrust clarification that physicians and our patients need. The passage of such legislation would increase the number and quality of competitors in the health care marketplace with resultant benefits for patients.

Antitrust reform is needed now due to the rapidly changing health care market. If present trends continue, the health care marketplace will be dominated by for—profit corporate entities

owned and operated by insurance companies and hospital holding companies. Today the big eight insurance companies own 44 percent of all the HMOs and PPOs, with their entire operational thrust creating even greater barriers to entry and precluding new competition.

These corporate entities are typically managed by nonphysicians whose major focus is on their own bottom line. One need only look at the recent Health Net case in which a patient was denied reimbursement for a bone marrow transplant initially recommended by her physician. The litigation led to a damage award of $89 million and a husband and children mourning the loss of a wife and mother. Just one example, we believe, of business priorities prevailing over patient interests.

Mr. Chairman, if time permits at the end of my statement, I have two examples from my own practice that would prove that point.

The CHAIRMAN. Please, Doctor. You have come all the way from Santa Monica. We want to hear you.

Dr. CORLIN. Thank you. The two examples, sir, are, one, a patient of mine who had seven family members with colon cancer. She herself, years previously, had had breast cancer for which she was treated successfully, and there is a statistical connection between breast cancer and colon cancer in women.

I requested authorization to do a screening colonoscopy on this very high risk patient, and it was denied by her for-profit insurance carrier.

My partner's wife 10 days ago had a bone marrow transplant at the Fred Hutchinson Institute in Seattle for leukemia. Our insurance in our office is Blue Shield. Blue Shield was started by the medical association, has long had a very heavy physician involvement on its Board, and maintains a strong outside Medical Policy Committee of physicians who are not salaried employees of Blue Shield.

Because my partner evaluated the various sites available in which bone marrow transplants are done, and the Hutchinson had the best data in terms of survival on women in their forties, he chose to go there. He contacted Blue Shield, asked them if they would be able to contract with the Hutchinson to list them as a preferred provider. It took them 2 days to respond, and they provided an affirmative response, in contradistinction to other companies lacking the physician involvement that said no.

Other witnesses have said that there is no empirical data to prove any of these points. To the contrary, such proof does exist, and I would like to offer it to the committee. In fact, a recent study by the California Medical Association found that as much as 31 percent of the premium dollars were diverted to insurance company profits, administrative costs, stockholder dividends, stock options, and bonuses to senior management.

Contrast that with the Kaiser-Permanente plans which place 95.3 percent of their premium dollar in patient care. With physician sponsored——

The CHAIRMAN. Could you identify that statement? We will place it in the record.

Dr. CORLIN. Yes, it is this statement, Senator.

The CHAIRMAN. I do not think we have it, but we will get it.

Dr. CORLIN. I will submit a copy to you immediately, sir.

[The statement appears in the appendix.]

Dr. CORLIN. With physician-sponsored plans, the savings go into patient care services not other services. We are also including the testimony of eight lawyers who have assisted doctors trying to establish physician networks. In each and every case, the antitrust laws were cited as the major obstacle thwarting these efforts.

Ironically, we now find ourselves in a paradoxical position where the antitrust laws are exerting a chilling effect on competition, rather than nurturing it. Some assert that antitrust relief could reduce incentives to improve the quality of care. To the contrary, allowing physician sponsored plans will enhance quality, for the values that physicians bring to their plans are the values that place patients first.

In addition, one of the proposed safe harbors outlined in each of the legislative proposals offered by Senators Chafee, Hatch, Thurmon and Nickles would protect standard setting and enforcement activities by hospital peer review committees and medical societies that promote health care quality.

May I continue for a few seconds?

The CHAIRMAN. Please do.

Dr. CORLIN. In the November 18, 1993 issue of the New England Journal of Medicine, Dr. Arnold Relman, the Journal's editor emeritus, expresses his concern that as the delivery of health care in America moves from independent practicing physicians to large integrated systems, it will be controlled almost entirely by giant for—profit corporations.

Dr. Relman asks, how can we ensure that corporate financial goals do not unduly influence the behavior of physicians? His answer is antitrust relief.

In conclusion, health care antitrust relief is needed as part of broad health care reform to permit physicians to address the needs of today and properly respond to changes we are all facing. Appropriate solutions such as those contained in the Hatch, Thurman, Chafee and Nickles proposals will contribute to the success of any model for health system reform that is ultimately adopted.

My message is really this. Give us back our ability to improve health care quality for our patients through appropriate antitrust reform.

Mr. Chairman, the AMA appreciates the opportunity to appear before this committee today, and we look forward to working with you and the Congress to resolve these concerns. At this time I request that my written and oral statements, as well as our submissions be submitted for the record. Thank you for the extra minute.

The CHAIRMAN. Without objection, for someone who has traveled 5,000 miles to get here.

Well, Mr. Weintraub, you have come all the way down from New York and we welcome you, sir.

STATEMENT OF ROBERT B. WEINTRAUB, J.D., STORCH & BRENNER, NEW YORK, NY

Mr. WEINTRAUB. Thank you, Senator. Mr. Chairman and other Senators, my name is Robert B. Weintraub. I am an attorney in

New York City and I am a member of the New York and District of Columbia Bars. I have experience in civil litigation including antitrust litigation.

I am a member of the law firm of Storch & Brenner which is located here in Washington, but I am in its New York office. The views I express today are my own and not necessarily those of Storch & Brenner. I appear before you today to testify about antitrust in the health care market and on S.1658, the Health Care Antitrust Improvement Act of 1993, which is included in multiple health care reform packages.

Although the health care industry today is fractured and mainly unconcentrated, antitrust lawsuits in the health care industry have been filed in ever increasing numbers. These lawsuits and the costs they impose on the judicial system are spiraling out of control.

Many of these lawsuits are essentially meritless. But even meritless antitrust cases can be very expensive to decide because of the complexity of the issues and the proof which is required.

My testimony is based on my experience in private law practice, particularly in the last few years. I have repeatedly been approached by potential clients seeking to sue either health care provider groups, including HMOs, hospitals or both, for alleged antitrust violations. I did not accept any of these cases.

In virtually every case, not only was there no antitrust claim present after extensive analysis, but the conclusion that no antitrust claim was present was really not even a close call. The common thread tying these matters together has been that the potential plaintiff was injured as an individual competitor, not that marketplace competition was injured.

As you know, it is competition in the marketplace, not individual competitors, which the antitrust laws are designed to protect.

Now in some of these instances, to be a little more specific, the plaintiffs or potential plaintiffs are individual doctors who are excluded from a health care provider group. In other instances, the plaintiffs or potential plaintiffs are individual doctors who lost their hospital privileges.

Often the alleged antitrust claim concerning dismissal or exclusion from the market was fundamentally unsound. In these matters, the doctors were denied the ability to compete in the relevant market because of incidents raising serious questions concerning the doctor's medical practices and competence.

In each of these instances, the doctor raised economic, that is marketplace related, concerns as the real cause underlying exclusion from the market. But the evidence supporting such a conclusion was virtually nonexistent in each instance.

Cases like these, however, are often brought by all kinds of plaintiffs against all kinds of defendants. There should be some way to decrease the costs of such litigation. S.1658 provides a good framework for discussing such a mechanism.

I would like to note that I was asked at approximately 4:00 p.m. yesterday to testify here today. Consequently, I am focusing my comments solely on certain aspects of the proposed legislation. S.1658 proposes——

The CHAIRMAN. You know, we expect New York lawyers to write briefs overnight. [Laughter.]

Mr. WEINTRAUB. I know and I definitely did it overnight.

S.1658 proposes a market power screen which excludes from antitrust scrutiny conduct where the defendant has less than a 20 percent market share. A market power screen may be a useful analytic tool whose time has come. One recent case illustrating the potential usefulness of a market power screen happens to be from New York, Mr. Chairman.

The case is *Capital Imaging Associates versus Mohawk Valley Medical Associates.* The cite is 996 F.2d 537, 2d Circuit, 1993.

In *Capital Imaging,* the United States Court of Appeals for the Second Circuit upheld the District Court's grant of summary judgment dismissing the antitrust claims. Plaintiff, Capital Imaging, is a private radiology group of doctors near Albany. The defendants were a small HMO, Mohawk Valley Physicians Health Plan, and the group of physicians organized to provide medical care to the health plan's enrollees, an independent practice association—Mohawk Valley Medical Associates.

Plaintiff alleged that it was improperly excluded from providing services to the patients of the HMO. The Second Circuit upheld the dismissal of the suit despite the fact that it agreed with the plaintiff that the plaintiff radiology group was excluded from the independent practice association of physicians for improper competitive reasons, in that case to insulate Mohawk Valley's member radiologists from increased competition.

Despite the anticompetitive intent, the case was dismissed because the defendant's market share ranged between 1.15 percent and 6.75 percent, depending on exactly what market definition you used.

Now these market share percentages rival the small market shares which were present in many of their early merger cases from the 1960's, which found the challenged acquisition unlawful. Those decisions have never been directly overruled by the Supreme Court and are still good law today.

But it must be remembered that the early merger cases were decided under the amended Section 7 of the Clayton Act. Section 7 applies an incipiency standard much more favorable to a plaintiff than the rule of reason standard under Section 1 of the Sherman Act. The market share percentages present in *Capital Imaging* are so minuscule that in virtually no circumstance could they support a finding of illegality under the rule of reason because a small defendant in a rule of reason situation simply does not have the power to injure competition.

May I continue, Senator?

The CHAIRMAN. Please, Mr. Weintraub.

Mr. WEINTRAUB. Thank you.

Nevertheless, the litigation lasted four or 5 years and I have been told that the defendants in Capital Imaging spent $500,000 in legal fees to win that lawsuit where they possessed less than a 7 percent market share. If so, that fact should be of serious concern.

S. 1658 proposes a 20 percent market threshold. That percentage is a reduction from the 25 percent contained in companion bill H.R. 3486. That reduction is a wise step. Even the 20 percent threshold contained in S.1658 should not be considered a magic number.

While there may be disagreement about where precisely to draw the line, a market power screen in an appropriate context has merit.

Now I understand that some individuals and groups consider this legislation to be "pro-Doctor." But there are certain sections of the proposal which clearly are just as favorable to HMOs and to hospitals as to doctors. For example, the legislation creates a safe harbor for standard setting and enforcement activities by medical self-regulatory bodies that are designed to promote the quality of health care provided to patients.

Such enforcement activities would include those taken by HMOs or hospital boards as well as medical societies unless done for financial gain. Thus, where a doctor loses hospital privileges over an issue concerning the quality of provided medical treatment, an antitrust suit would be barred, unless the malpractice accusations against the doctor were a sham and the true reason for the termination of privileges was competitive gain.

Ultimately, however, most antitrust issues will be decided in the courts in individual litigations. In those circumstances, the best solution is and remains very smart judges; strong judges; judges who have a sense of commerce and industry in America, an even-handed approach to enforcing the antitrust laws, and the personal strength to grant either motions to dismiss or motions for summary judgment, dismissing lawsuits where appropriate; and, to impose sanctions for frivolous lawsuits where appropriate.

I appreciate the opportunity to appear before the Senate Finance Committee, Mr. Chairman. I would be happy to answer any questions.

The CHAIRMAN. We thank you for a bravo performance written on the eastern shuttle.

Mr. WEINTRAUB. Thank you.

[The prepared statement of Mr. Weintraub appears in the appendix.]

The CHAIRMAN. And now, Dr. O'Neil-White, befalls you the distinction, I hope, of being a concluding witness in a year long term of Senate hearings by the Finance Committee, our first ever in this range of this subject. You are here as Vice President and General Counsel of the Group Health Association of America. Good afternoon, sir.

STATEMENT OF ALPHONSO O'NEIL-WHITE, J.D., VICE PRESIDENT AND GENERAL COUNSEL, GROUP HEALTH ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. O'NEIL-WHITE. Mr. Chairman, thank you. I am Vice President and General Counsel of Group Health Association of America. We refer to it as GHAA. GHAA is the national association of health maintenance organizations, HMOs, who represents about 360 HMOs nationwide that provide health care to 33 million Americans.

Those HMOs represent a range of health plans from the 3,500 member Heart of America plan in North Dakota to the multi-million member Kaiser-Permanente Health Plan in Southern California. They include physician-owned and controlled plans, plans that

are controlled and owned by insurance companies, as well as plans that are controlled by consumers, consumer cooperatives.

Today, roughly one of every five Americans who have health insurance are enrolled in HMOs. GHAA estimates that HMO enrollment will exceed 50 million by the end of 1994.

The CHAIRMAN. Wow.

Mr. O'NEIL-WHITE. Even if HMO enrollment continues at these growth rates, fee-for-service medicine will remain healthy, viable, leaving consumers with healthy options for receiving quality health care.

On behalf of our member companies and their enrollees we appreciate your invitation to speak to you today. Today we will discuss an issue of utmost importance, one to health care consumers like you and me, to our industry and to the future of health care reform. The issue as we view it is this, whether there is a demonstrated need to fundamentally change the current antitrust laws.

The basic purpose of the antitrust laws and antitrust enforcement in the health care industry is to promote and preserve competition, not to protect competitors or to provide shelter for special interest groups.

Competition promotes consumer choice, cost containment and innovative approaches to health care delivery that benefit consumers. These are the specific goals of health care reform. No amount of structural reform in the health care industry, however, will succeed if providers are organized into tightly knit cartels that reduce output, lower quality, increase prices, stifle innovation or restrict entry into communities.

Vigorous and sound antitrust enforcement is the best mechanism for preventing price fixing, boycotts, market allocation schemes and anticompetitive mergers or joint ventures that inevitably lead to higher prices for consumers or exclude competitors from a dynamic and rapidly changing marketplace.

Thus, antitrust enforcement is essential to achieve many of the fundamental goals of health care reform. Today's health care marketplace demonstrates that existing antitrust laws promote procompetitive collaboration by providers. The fact is, the existing antitrust laws have benefited health care consumers by removing obstacles to the formation and expansion of HMOs as an alternative to fee-for-service medicine.

In fact, they have also facilitated physician controlled networks and other integrated delivery systems. It is important that there be a level playing field for all types of health plans, whether they are generated and controlled by physicians, insurers, HMOs or other providers.

Unfortunately, the legislation being proposed for consideration by Congress would protect some of the types of anticompetitive activity that would directly threaten the viability of HMOs and other alternatives to fee-for-service medicine.

GHAA opposes any policy or legislation that would protect such anticompetitive activity. Some of the proposals would create broad antitrust exemptions that go far beyond the existing antitrust law without any empirical data to justify the need for sanctioning such activity. In fact, the legislation would likely undermine the consumer protection that current antitrust laws are intended to

provide—protection that have also enabled integrated health care delivery systems to flourish while retaining fee-for-service medicine is a real and effective option.

Antitrust enforcement has played a significant role in keeping markets open to HMOs by stopping conspiracies to boycott or price fix or by preventing the unlawful use of market power by provider groups to exclude HMOs and managed care plans from health care markets.

We expect antitrust enforcement to continue to play a critical role as HMOs enter new communities. This will be particularly critical in small town America where HMOs face many difficult challenges because rural Americans live far away from providers and major medical centers. Rural populations tend to be slightly older, have lower incomes, lower incomes than their urban counterparts and their demand for medical services tends to be higher, while access to providers more limited.

HMO providers, however, have treated the challenges in rural America as opportunities rather than obstacles. Examples abound that demonstrate a number of innovations in rural health care delivery systems have been implemented successfully within the framework of the current antitrust laws.

In other words, cost effective, efficient, and pro—competitive arrangements are occurring as we speak without being hampered by the existing antitrust framework.

Mr. Chairman, I will take another 30 seconds if I may.

The CHAIRMAN. Please do, sir.

Mr. O'NEIL-WHITE. We expect this activity to continue to occur and to expand. We urge this committee to consider the essential role that the antitrust laws have played in the historical development of managed care as a viable alternative to fee-for-service medicine and to recognize that the future of similar innovations in health care delivery in urban and rural America will depend in large part, on the continued role of sound, vigorous antitrust enforcement.

GHAA wishes to thank the committee and the Chairman for this opportunity to express its views on this very important issue. We reaffirm our commitment to work with the committee and other members of Congress as the health care reform debate proceeds.

Thank you, Mr. Chairman.

The CHAIRMAN. We thank you, Mr. O'Neil-White.

[The prepared statement of Mr. O'Neil-White appears in the appendix.]

The CHAIRMAN. I think we turn now directly to Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

I have been very interested in this subject as you can imagine. I want to personally thank you, Mr. Weintraub for coming down at the last minute and bringing your eloquent testimony in support of our bill.

And, of course, Dr. Corlin, we appreciate you and others who have assisted on this particular bill.

I would have to say that, Mr. O'Neil-White, you have stated that the antitrust system is working "perfectly," and I may want to get into a few short questions with you.

But let me just start with this. Some criticism of S.1658, particularly that which comes from GHAA has been aimed at the safe harbor which provides a 20 percent market power screen exempting small combinations from any antitrust scrutiny.

I would like, Mr. Chairman, to have included in the record a letter in support of the bill by Dr. James Langenfeld, who up until January of this year, was the Director of Antitrust in the Bureau of Economics at the Federal Trade Commission. Dr. Langenfeld states, and I quote, "As indicated in the economics literature market power is a necessary ingredient for any group of competitors to raise price above the competitive level. A market share of only 20 percent is extremely unlikely to allow any group to raise prices unilaterally without losing significant sales to the other competitors in the market." Commenting upon the whole legislation Mr. Langenfeld said, "I believe many aspects of the bill would facilitate the formation of more efficient, competitive organizations in an era of radical change in the health care industry. Accordingly, I believe the bill deserves serious consideration."

Mr. O'Neil-White, what would be your response to that? Would any of you others care to comment on Dr. Langenfeld's remarks in his letter?

Mr. O'NEIL-WHITE. Well, Senator Hatch, our position is that the current antitrust laws will allow providers to collaborate in those delivery systems, those networks if they are integrated, if they share risks, if there is some financial risk within that organization.

But I think that under the bill as proposed that would not be necessary, basically you are saying that providers will be allowed to get together and form not a joint venture but a cartel. A joint venture is a separate economic entity where the participants share risks. I think that is important because unless they share risk, they have no incentive to improve quality, increase access and do all those other good things.

Senator HATCH. It costs a lot of money through litigation to find out whether they are integrated. Frankly, I do not know anybody who would call 20 percent a cartel.

But what do you think, Ms. Steptoe?

Ms. STEPTOE. Well, as the second point on the issue of expense, I would like to reiterate the point I was making that if you have questions about whether your organization is sufficiently integrated to avoid antitrust risk, that is where the antitrust agencies are trying to improve our outreach efforts. Call us on the phone or write for an advisory opinion.

Senator HATCH. Sure.

Ms. STEPTOE. And you can get your answer very quickly.

Senator HATCH. So you do not disagree with Dr. Langenfeld's conclusion?

Ms. STEPTOE. I think Dr. Langenfeld's conclusion is directly opposed to what the Supreme Court has laid down as the law. If he is saying that the market——

Senator HATCH. Keep in mind what we are trying to do here now is write the law so we solve a lot of problems and save a lot of money.

The CHAIRMAN. We are changing that.

Senator HATCH. We do not care what the Supreme Court is doing in that sense.

Ms. STEPTOE. Well, as a lawyer charged with enforcing the law as it is right now, I do have to make the point that what he is advocating is a change of what has been the law for over a century.

Senator HATCH. That is what I am advocating.

Ms. STEPTOE. All right. And you are advocating that change——

Senator HATCH. Assuming that we can advocate and assuming that we can change the law so that it is not an unconstitutional change, do you agree with Mr. Langenfeld under those circumstances?

Ms. STEPTOE. Even so, I would tend to side with Mr. O'Neil-White on this. I ask simply, what good is accomplished by letting competitors, whatever their market share, get together for the sole purpose of raising the prices they charge for the services they offer? I do not see that that helps consumers at all. I do not see that it improves the quality of care or the variety of offering that are made or innovation. I think the test is precisely as Mr. O'Neil-White said: that is, whether providers have integrated in such a way that their financial incentives are to bring something new to the marketplace, to bring something better or cheaper to the marketplace, to override their own individual incentive which is to charge to the maximum.

Senator HATCH. Mr. Weintraub?

Mr. WEINTRAUB. The Supreme Court talked about providing certainty to businessmen and businesswomen in its decision in *Philadelphia National Bank* many years ago, which was a merger case. Similarly, if there were a statute today in this area, it would provide certainty for business persons to make business decisions without looking over their shoulder at potential costly private antitrust suits.

Senator HATCH. Dr. Corlin?

Dr. CORLIN. Senator Hatch, we would obviously agree with that. The reason is the very comment that the gentleman on the end of the panel gave. We are seeking the same opportunities and level playing fields that the commercial providers and the insurance companies now have.

The importance of providing this 20 percent threshold is to allow physician networks to go through the same step-by-step process to get to a fully at-risk, if you will, capitated program. None of these programs started out that way. If they had begun that way on day one, they all would have failed. And the insurance company's desire to prevent physician groups from going through the step-by-step process of first, a PPO, then a withhold, then a capitated system, and develop the at-risk phenomenon in steps.

The reason they want to deny that to physician groups is to prevent any competition from coming in. The advantage that physician run programs can have is that we will not be diverting 31 percent of the premium dollar to other than health care services.

Senator HATCH. So you are saying this would increase competition?

Dr. CORLIN. Yes, sir.

Senator HATCH. Now let me ask you, could you tell us about the difficulties individual providers face in creating collaborative arrangements that can add to competition in the health care market?

Dr. CORLIN. It is absolutely impossible under the present circumstances to begin any sort of a managed care program without starting fully at risk, and the economic reality is you cannot begin economically fully at risk until you get your systems in place just as the present companies in the market have done.

Senator HATCH. And this bill will enable that to happen?

Dr. CORLIN. It would enable it to happen. The other thing, Senator, is I understand what the law is to the extent of my ability to understand the law, and I understand the theory behind its use with regard to antitrust. The reality is that the fear of antitrust litigation prevents innovation.

Senator HATCH. I think that is right.

Now, Mr. O'Neil-White, you have said that the antitrust system is working "perfectly." I would just like to ask you a few short questions. Following in Senator Chafee's wise footsteps, I would also like to ask you if you can, to the extent possible, keep your answers to "yes" or "no," but if you must, please expand them.

The CHAIRMAN. Because we are getting close to a bell.

Senator HATCH. Are we running out of time?

The CHAIRMAN. I want to let Senator Durenberger and Senator Rockefeller inquire.

Senator HATCH. Sure.

The CHAIRMAN. One question and your answers are yes, no.

Senator HATCH. Well, I have a series of them. Can I wait?

The CHAIRMAN. Sure.

Senator HATCH. All right. Do you not agree that the current system is expensive?

Mr. O'NEIL-WHITE. I cannot say, Senator, that it is expensive.

Senator HATCH. I think it is very expensive. Is it not as the joint policy statement of the DOJ and the FTC suggest that improvements are really needed and really possible; is that not true?

Mr. O'NEIL-WHITE. That is what the statement says, yes.

Senator HATCH. That is what it states, yes. If you believe the antitrust agencies are doing a good job, would they not do an even better job under the processes provided for in my bill?

Mr. O'NEIL-WHITE. Well, I cannot say that either, Senator. I think that, as I said, the current enforcement scheme has allowed a great many of these activities to occur and they are occurring right now all over the country.

Senator HATCH. The cost is $4 million unnecessary dollars in Utah, I have to tell you, that could have gone to health care or to the poor.

Given the fact that market power is necessary for entities to have a negative effect on competition, what is wrong with market power screens which focus enforcement away from small actors to actors large enough to affect competition?

Dr. O'NEIL-WHITE. Senator, I do not see and I have said before, there is no evidence to suggest that this needs to occur, that you

need to have a situation where physicians or other provides can get together in unintegrated organizations.

The CHAIRMAN. I am going to have to ask that we move across because Senator Durenberger wants to ask some questions.

Senator HATCH. Fine.

The CHAIRMAN. Is that all right, sir? We can return.

Senator HATCH. Sure.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you very much. I do not have a position other than indirectly on any of the bills. I do compliment my colleague from Utah for his leadership in antitrust laws in general. But I just want to say listening to the tone of his question and having read at least some part of Ms. Steptoe's statement, this is like the 1930's all over again.

You put this together with the proposal that we have $2,000 or $3,000 deductibles for all Americans and sell catastrophic insurance only and you are guaranteed to go back to the fee-for-service medical system and the indemnity insurance system that has given us the problems that we have.

You talk about 31 percent insurance company profits, I mean that is right out of the 1930's and the 1940's. The implied tax on the integration, whether it is a group health practice or something like that, I mean, I really find it hard to believe right here at the very end of this process that this is the progress that we have made towards understanding the value of the consumer's choice and competition and quality and value in medicine.

I will grant you, Dr. Corlin, and we had a wonderful time together in making speeches, one right after the other, in one of those spas we cannot go to anymore, called Palm Springs, just a couple weeks ago. [Laughter.]

Dr. CORLIN. I paid my own way.

Senator DURENBERGER. Yes. And he had to go off and deal with his own personal problem in your own community in terms of a joint venture and things like that.

I must say to you, Mr. Chairman and my colleagues, I spent the last couple months in my State trying to encourage doctors to get out ahead of this curve. I say and I will say it here publicly, I do not want to buy my health care 10 years from now from the President of some insurance company. I want to get it from physicians.

But I hope that they are properly motivated and that the system is the kind of system in which risk is shared and results are the object. We are running a system in which everybody gets paid a fee for a service. They have their own little part of the business and the end result is a trillion dollars a year.

So I cannot think, here we are right at the end and we are running out of time, and we spent 2½ hours on medical liability which everybody on this panel has already made up their mind. This is the most challenging subject with which we are going to have to deal.

So even though I have started this out as sort of a throw back way, I really want it to be considered from just my standpoint as a challenge, particularly to physicians, to help us deal realistically with the market reforms that are in their best interests.

Promoting any willing provider laws in every State in this country is going back to the 1930's, guys. Forget it. Forget it. And whoever is behind it, get rid of it. That is not in your best interests. It is not in anyone's best interests.

The CHAIRMAN. I am going to have to on that rather precise note say that roll call having begun, Senator Rockefeller, there are about 11 minutes left on the roll call.

Senator DURENBERGER. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Mr. Chairman, I have a number of questions but I understand the situation.

The CHAIRMAN. We are not into our buzzer.

Senator ROCKEFELLER. In that case, I might say, Dr. Corlin, let me just ask you, you said you are a member the of the House of Delegates. When you voted, did you vote against mandates?

Dr. CORLIN. You mean employer mandates?

Senator ROCKEFELLER. Yourself, personally.

Dr. CORLIN. Well, I do not vote because I was running the meeting. But let me explain that, sir.

Senator ROCKEFELLER. Do not explain the situation to me. Would you have voted against it?

Dr. CORLIN. No, I would not have. I would have voted for the employer mandate. And the reality, Senator, if I may, that was the most widely misreported item in our entire meeting. There was a motion made——

Senator ROCKEFELLER. Can I go on, because you told me what I wanted to hear.

Dr. CORLIN. There were only 2 votes out of 400 to vote against the employer mandate, sir.

Senator ROCKEFELLER. Good. Well, that is very good because that takes away my previous argument that if you are going to have people like me and Senator Hatch and Senator Durenberger fighting to help you on malpractice reform and antitrust reform, then you have to give something back the other direction.

Dr. CORLIN. We understand.

Senator ROCKEFELLER. And unfortunately a lot in the AMA are not.

Let me just say this to Ms. Steptoe. In West Virginia, an area that has several small hospitals, none of which can sustain themselves, and are going out of business as many of ours have; what is so evil about those hospitals getting together and deciding to divide up what it is they do so that they can serve the area more efficiently and not duplicate each other?

Ms. STEPTOE. There are several concepts in there. One is, if you are actually talking about the merging, chances are they fall into the "small hospital safe harbor."

Senator ROCKEFELLER. Merging?

Ms. STEPTOE. Yes, sir. I am taking your premise that the hospitals are small and under capacity and inefficient. Very likely they could look in the Health Policy Statements and find that they are of a size that they can merge and be in a safe harbor. Secondly, you may be asking if they can do something less than a merger—a joint venture to maybe have a mobile lithotripsy unit or share high tech medical equipment, a helicopter or something like that.

Again, chances are very likely that hospitals can read the health policy statements and get clear direction that they can joint venture among themselves since the premise of your statement would be that no one could afford to purchase the equipment by themselves, that they need to combine forces to solve the problem.

Senator ROCKEFELLER. So that kind of collusion, unlike what Senator Metzenbaum said would be allowed and perhaps is useful.

Dr. STEPTOE. I would not call it collusion, I would call it——

The CHAIRMAN. Cooperation.

Senator ROCKEFELLER. Cooperation. The word is collude. That is the word we use in the bill—collude.

One final question for Dr. Corlin, and I thank the Chairman. We have many more specialists and generalists in this country. If State medical associations were allowed to negotiate on behalf of doctors in terms of antitrust in this, if some of us got what we want to get in antitrust, would that not put specialists in the position of being able to dominate generalists and primary care physicians and perhaps put generalists at a disadvantage? And how would you make sure that that would not happen?

The CHAIRMAN. In two minutes or less.

Dr. CORLIN. Yes, sir. I think from an economic basis, as a specialist myself, it is the specialists who were disadvantaged. It is my belief, and I believe there is a fair amount of evidence for it, that both for physicians and lawyers, a surplus drives up the costs of care, not down.

I think it is a shame that we are training large numbers of physicians in many specialties that we do not need. It is a shame for the community. It is a shame for the money that is spent on care and it is a shame for those individuals. It is absurd to have somebody spend 7 years in residency as a neurosurgeon to go out and practice in an environment where they are doing an average of two operations a week.

I would like to see us be able to train only those physicians which the community really needs. That means training less specialists and more generalists. In an approach to that, it gets very dicey as to how can you do that without violating the antitrust laws.

I would like to be able to see us approach that in a more coordinated manner so that we do not protect physicians' incomes, but also that we do not waste money and waste intellect in training physicians who are not needed, who will have an incentive to provide care that is not necessary.

When I finished my training at UCLA in 1972, I——

Senator ROCKEFELLER. Dr. Corlin, let me just say that I appreciate your answer. You are my kind of doctor. I thank the Chair.

Dr. CORLIN. Thank you.

The CHAIRMAN. You gave the right answer then. [Laughter.]

Senator HATCH. Mr. Chairman.

The CHAIRMAN. Yes, sir.

Senator HATCH. May I just direct one last comment to Mr. O'Neil-White?

The CHAIRMAN. Please, sir. But it is going to have to be the last. Look at those lights.

Senator HATCH. It will be short. What I would like, Mr. O'Neil-White, rather than trying to poke holes in our bill, which I think you have done, cannot GHAA work with us to try and resolve the problems and work with us to make a system that would address the problems we have heard about in the testimony before this committee?

Mr. O'NEIL-WHITE. Yes.

Senator HATCH. And if you want, I think we can maybe come to something that might bring everybody together.

The CHAIRMAN. Good. And on that note——

Senator HATCH. And we are open.

Mr. O'NEIL-WHITE. And we are perfectly happy to work with you, Senator.

The CHAIRMAN. We are glad. You are right here in town. We look forward to it. We thank everybody for coming. You could not have been better witnesses. We appreciate your candor and with that our hearings conclude.

[The prepared statement of Senator Harkin appears in the appendix.]

[Whereupon, at 12:55 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted

Prepared Statement of Troyen A. Brennan

INTRODUCTION

Title V of President Clinton's Health Security Act addresses malpractice issues. Sections 5301–5312 are devoted to changes in medical malpractice that would preempt state law. In particular, the Administration recommends use of mandatory, but non-binding alternative dispute resolution mechanisms including mediation and arbitration;[1] requires plaintiffs to submit certificates of merit before initiating a suit;[2] limits contingency fees to 33⅓ percent;[3] requires mandatory collateral source offset[4] and the periodic payment mechanisms;[5] and recommends experiments with exculpatory use of practice guidelines and enterprise liability.[6]

Recent reports by the Office of Technology Assessment of the Congress of the United States and the General Accounting Office suggest that these reforms will have some impact on rates of malpractice litigation.[7] While there is little evidence to indicate that alternative dispute resolution, certificates of merit, or periodic payment mechanisms will have much effect on the amount or intensity of malpractice litigation, studies do reveal that mandatory collateral source offsets and limits on contingency fees will reduce the number of claims. However, many states have already adopted these reforms and so the federal law's impact may be minimal. Use of guidelines as exculpatory evidence will likely reduce the total number of claims, especially if inculpatory use of practice guidelines is prohibited as the Health Security Act envisions. Thus one can expect a modest reduction in rates of litigation, which will please providers. Alternatives like the Managed Competition Act of 1993 (Cooper Bill) have more significant restrictions on contingency fees and also place a cap on pain and suffering damages, and so will likely reduce rates of litigation more sharply than would the Health Security Act.

But such reforms may also have detrimental effects. Tort litigation is intended to compensate individuals who have been injured and deter practices that lead to injuries. Most of the proposals by the Health Security Act will not improve the ability of the tort system to undertake these critical functions. In fact, if enacted, the Health Security Act will likely lead to less compensation for individuals injured by medical practice, will reduce deterrence of practices that cause such injuries and overall could increase the costs of the medical care system. Moreover, contingency fees limits and collateral source offsets will likely make it more difficult for poor patients to bring suits. Mandatory arbitration practices will lengthen the process of litigation. The detrimental effects of alternatives like the Managed Competition Act could be even greater. In this testimony, I will overview recent empirical evidence that puts the Health Security Act and other federal malpractice reforms in perspective.

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[1] Health Security Act §5302.
[2] Health Security Act §5307.
[3] Health Security Act §5304.
[4] Health Security Act §5305.
[5] Health Security Act §5306.
[6] Health Security Act §5311 and §5312.
[7] *See* United States Congress Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs* (September 1993); United States General Accounting Office, Report to Congressional Committees: Medical Malpractice: Alternatives to Litigation (January 1992).

MEDICAL INTROGENIC INJURIES ARE ASSOCIATED WITH SIGNIFICANT MORBIDITY AND MORTALITY AND LARGE COSTS

Analyses of over 30,000 medical records in the State of New York for care rendered in 1984 indicate that of the 2.6 million people discharged from hospitals, 98,000 suffered adverse events, defined as injuries caused by medical practice as opposed to the disease process, 27,000 of which were due to negligence.[8] The overwhelming majority of adverse events led to minimal impairment or short prolongation of the hospitalization. However, 2,500 of these injuries caused permanent impairment with greater than 50 percent disability. Moreover, medical adverse events were associated with 13,000 deaths. Of these deaths, nearly 7,000 were caused by negligence, or care that failed to meet the standard expected of the reasonable medical practitioner (Table 1).

TABLE 1.—POPULATION ESTIMATES OF DISABILITY CAUSED BY ADVERSE EVENTS, NEW YORK 1984+

Disability category	Adverse events No.	Negligent adverse event No.
Minimal impairment, recovery 1 month	56,042	12,428
Moderate impairment, recovery 1–6 months	13,521	3,302
Moderate impairment, recovery >6 months	2,762	817
Permanent impairment, 1–50% disability	3,807	869
Permanent impairment, >50% disability	2,550	877
Death	13,451	6,895
Cannot reasonably judge disability	6,477	1,989
Totals*	**98,610**	**27,177**

*Totals differ from sums of those reported above because of rounding error.
+These are the estimates of the number of Patients disabled by medical care, and the subset due to negligent medical care, at various levels of impairment for New York in 1984.

These adverse events were associated with great costs.[9] In 1984 dollars, adverse events caused $467 million in lost earnings and $1.8 billion in medical care costs in New York. If the medical care costs are adjusted to 1993 health care dollars and extrapolated from New York to the entire country, medical injuries are associated with over $60 billion in costs, all of which the medical care system and other social welfare benefit plans now silently absorb. As we shall see, reimbursement of medical malpractice liability insurance covers very little of these costs. The figure of $60 billion is larger than the combined estimates of the costs of medical malpractice premiums ($10 billion) and defensive medicine ($10–$20 billion).

The costs of medical injuries and the total morbidity and mortality associated with adverse events and negligent adverse events underline the need for greater efforts at prevention of medical injuries. This matter of great public health importance is not clearly addressed by the Health Security Act or other suggested federal reforms. The failure to address prevention is the single greatest weakness of current federal reforms of malpractice.

The epidemiology of medical injury provides other lessons for health care reform. Medical injuries are distributed unevenly. The major individual socioeconomic risk factor for suffering a negligent medical injury is lack of insurance.[10] In this regard, the President's insistence on universal access is critically important (Table 2). Clearly quality of medical care is linked to ability to pay, and any moderation in the commitment to universal access will prolong the two class care system that now exists in this country.

[8] Brennan TA, Leape LL, Laird NM, et al. *Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study II. N ENGL J MED 1991;324:377–384.*

[9] Johnson WG, Brennan TA, Newhouse JP, et al. *The economic consequences of medical injuries: implications for a no-fault insurance plan.* JAMA 1992;267:2487–2492.

[10] Burstin HR, Lipsitz SR, Brennan TA. *Socioeconomic status and risk for substandard medical care.* JAMA 1992;268:2382–2387.

TABLE 2.—MULTIVARIATE ANALYSIS OF INDIVIDUAL-LEVEL RISK FACTORS: ADVERSE EVENTS AND NEGLIGENCE

	Adverse events (AE) Ratio (95% CI)+	% AES due to negligence risk ratio (95% CI)+
Male gender	0.96 (0.83–1.10)	0.84 (0.59–1.20)
Black race	1.13 (0.84–1.51)	1.48 (0.80–2.75)
PAYER STATUS:		
Uninsured	0.84 (0.59–1.18)	2.35 (1.40–3.95)*
Medicaid	1.27 (0.97–1.65)	1.34 (0.70–2.55)
INCOME:		
Poor	1.15 (0.90–1.46)	1.18 (0.62–2.24)
Near Poor	0.91 (0.67–1.24)	0.79 (0.34–1.84)
Low Income	0.64 (0.490.84)**	0.85 (0.41–1.75)
Middle Income	0.94 (0.79–1.12)	0.97 (0.50–1.90)

Calculated from multiple logistic regression, controlling for Patient age and diagnosis-related risk.
*p <.001, compared to the privately insured.
**p <.05, compared to higher income.
+Confidence Interval.

At a hospital level, the major risk factor associated with negligent injury is the total amount of resources expended in the care of patients.[11] Individuals hospitalized at institutions in the lowest quartile of total operating costs are at much higher risk of suffering a negligent medical injury than are other patients. As Congress attempts to control costs, it must ensure that resources are carefully and evenly distributed. Otherwise patients hospitalized at relatively poor hospitals will be at much greater risk for negligent injury.

MEDICAL MALPRACTICE CLAIMING IS NOT MATCHED TO MEDICAL INJURIES

A review of over 68,000 medical malpractice claims in New York State uncovered 3,600 claims that arose from treatment year 1984. Since each of the 27,000 negligent adverse events theoretically could and should give rise to a medical malpractice claim, it appears that only one out of seven potential claims are actually being brought. Previous investigations have made the same point: there is a large litigation gap in medical malpractice.[12]

The more recent research combined the review of all 30,000 records with the 68,000 malpractice claims, and matched claims to individual cases. In this matching process, 51 claims were uncovered in which there was also review of the medical record, allowing estimates of the sorts of cases in which claims were being brought. Many claims (over 80 percent) are brought in cases in which there is no adverse event or no negligence.[13] On the other hand, less than 3 percent of negligent adverse events lead to claims (Table 3).

TABLE 3.—ESTIMATES OF ADVERSE EVENTS, NEGLIGENT ADVERSE EVENTS AND CLAIMS, NEW YORK 1984+

	Hospital patients	Claims
No Adverse Event	2,573,253	2,267
Adverse Event	71,433	783
Negligent Adverse Event	27,177	625
Total	2,671,863	3,675

+These numbers reflect the combination of the results of the matching of claims in New York with the medical record review results. They show the estimated number of claims arising from three categories of patients: those classified as having Do adverse event; those with a non-negligent adverse event; and those with a negligent adverse event.

Overall, the medical malpractice system appears quite inaccurate. Indeed it is similar to a situation in which a traffic officer is giving tickets to large numbers

[11] Brennan TA, Hebert LE, Laird NM, et al. *Hospital characteristics associated with adverse events and substandard care.* JAMA 1991;265:3265–3269; Burstin HR, Lipsitz SR, Brennan. The impact of hospital financial performance on quality of care. JAMA 1993;270: 845–849.

[12] *See Patricia Danzon, Medical Malpractice. Cambridge, MA: Harvard University Press (1985).*

[13] Lolio AR, Lawthers AG, Brennan TA, et al. Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III. N Engl J Med 1991;325:245–251.

of motorists who are not speeding, but failing to give tickets to many speeding motorists. The Health Security Act, insofar as it emphasizes mandatory collateral source offsets and use of guidelines for exculpatory purposes, will reduce overall claiming. As a result, it is likely to reduce some of the false claims, those brought in cases in which there is no injury, but it will also reduce claims brought in cases in which there was a negligent adverse event, further reducing the already scanty compensation available to the majority of injured patients. Alternatives like the malpractice package contained in the Managed Competition Act of 1993 will bring about even further reduction of claims.

The current medical malpractice system is also inequitable, in that certain types of patients are far less likely to bring medical malpractice claims, even when suffering significant medical injuries. For instance, uninsured patients are one tenth as likely to bring claims as patients who have insurance.[14] Poor patients are one fifth as likely to bring claims as are the wealthy. The aged are also unlikely to bring claims. Since the Health Security Act and alternatives limit contingency fees, and since the poor are more dependent on contingency fee mechanisms in order to bring claims, federal reform will likely worsen the inequity of the tort system. The poor will be even less likely to sue than they are at present.

THE TORT SYSTEM DOES APPEAR TO DETER POOR PRACTICES

While the deterrence signal sent by the medical malpractice system must be somewhat confused, given the overall mismatch between malpractice litigation and medical injury, there is evidence that physicians are aware of and react to varying levels of medical malpractice litigation. For instance, physicians are able to gauge their risk of being sued. In fact, their perceived risk of being sued is much higher than their actual risk of being sued.[15] This means that while the signal is weak, physicians are understanding it.

More importantly, empirical analyses suggest that the risk of negligent injury for patients deck as claims increase.[16] Tort litigation, with all of its warts, may accomplish the task for which it is primarily intended, that is the prevention of medical injury.

The Health Security Act is aimed primarily at reducing medical malpractice claims. This will reduce compensation available to patients. More importantly, however, by reducing claims rates, it will reduce deterrence, and increase rates of medical injury. In addition, total costs associated with medical injury will increase.

USE OF PRACTICE GUIDELINES SOLELY FOR EXCULPATORY PURPOSES WILL REDUCE MALPRACTICE CLAIMS

Research undertaken for the Physician Payment Review Commission clearly indicates that practice guidelines are now being used in malpractice litigation.[17] Plaintiff attorneys are much more likely to use practice guidelines than are defense attorneys. This should not be surprising in light of the Medical Practice Study results. There is a large reservoir of potential claims. If practice guidelines provide an inexpensive and durable demonstration of the standard of care, and so make the proof of negligence easier, plaintiff attorneys are more likely to apply them than are defense attorneys.

The recent experiments with practice guidelines in Maine and other states exclude use of practice guidelines for inculpatory purposes and allows them only for exculpatory purposes. The Health Security Act follows the same format. This one sided use of practice guidelines appears unjust. Since there is huge morbidity and mortality associated with negligent injuries, it would seem advisable to use practice guidelines for both inculpatory and exculpatory purposes.

ENTERPRISE LIABILITY AND NO-FAULT REFORMS

The Health Security Act recommends studies of enterprise liability. Enterprise liability exists today in some institutions. For instance, practitioners at the Brigham and Women's Hospital and the Harvard Community Health Plan in Boston, Massa-

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[14] Burstin HR, Johnson WG, Lipsitz SR, et al. *Do the poor sue more? A case-control study of malpractice claims and socioeconomic status.* JAMA 1993;270:1697–1701.

[15] Lawthers AG, Localio AR, Laird NM, et al. *Physicians' perceptions of the risk of being sued.* Journal of Health Politics, Policy and Law 1992; 17:463–482.

[16] Paul C. Weiler, Howard H. Hiatt, Joseph P. Newhouse, William G. Johnson, Troyen A. Brennan and Lucian L. Leape. A Measure of Malpractice: Medical injury, malpractice litigation, and patient compensation. Cambridge, MA: Harvard University Press, 1993.

[17] Brennan TA, Hyams AL. Practice guidelines and malpractice litigation: report to the Physician Payment Review Commission (February 1, 1994).

chusetts already practice medicine in a mature enterprise liability system: both claims against the institutions and the physicians are handled by a coordinated defense team for the single insurer. There is, however, little evidence that physicians under enterprise liability have different attitudes towards medical malpractice than do others. Nor is there any sense that medical injury rates are higher or lower in these institutions than elsewhere. Therefore enterprise liability by itself may have little impact on malpractice litigation.

However, if enterprise liability was linked to a system that eschewed findings of negligence and instead compensated on the basis of medical injury, one could hypothesize that there would be significant gains both in terms of prevention and compensation. The New York State research has demonstrated that a no-fault injury mechanism in medicine would be a viable alternative. For instance, the total costs of a no-fault compensation system could be accomplished for the same cost as the total amount of premiums now being paid by providers. Moreover, if medical care payments were absorbed by the health care system, as the Health Security Act envisions, no-fault insurance for the remainder of injuries is quite affordable. More importantly, all medical injuries would be compensated, not just those due to negligence. A no-fault approach also has significant benefits from a prevention point of view. If linked to enterprise liability and experience rated premiums paid by those enterprises, one could produce significant deterrence signals at the level of the enterprise.

Most importantly, no-fault could lead to new physician attitudes with regard to medical injury compensation. A similar system in Sweden is widely accepted by physicians. In fact in that country, over 90 percent of claims are initiated by physicians on behalf of injured patients. A no-fault process also accommodates notions of continuous quality improvement and epidemiological methods to reduce medical injury. American physicians are prepared to report medical injuries in a systematic effort to identity risk factors for medical injuries, and then to prevent them.[18] Our major effort in malpractice reform should be directed at preventing medical injuries to patients and compensating them for their injuries.

SUMMARY AND CONCLUSIONS

Many of the Health Security Act provisions are somewhat neutral with regard to an impact on medical malpractice litigation. Arbitration, periodic payment, and similar reforms will simply lengthen the duration of the litigation process. They will likely not affect claiming behavior. Changes in the contingency fee, however, will reduce the ability of the impoverished to bring suits still further. This will make the medical malpractice system even more inequitable than it is today. Collateral source offsets and use of guidelines will reduce claims, which is what many insurers and medical professional societies intend. However, these reforms will reduce deterrence and thus increase the number of medical injuries and the costs associated with those injuries. They will also reduce compensation for individuals who have been injured. Overall, I recommend experiments that incorporate no-fault concepts of compensation, and experience rating-based approaches to deterrence.

PREPARED STATEMENT OF CLIFTON R. CLEAVELAND, MD

Good morning. My name is Dr. Clifton R. Cleaveland. I practice internal medicine in Chattanooga, Tennessee. I am President of the American College of Physicians (ACP). With a membership of more than 81,000 physicians who practice internal medicine and its subspecialties, the College is the nation's largest medical specialty society. Internists provide more medical care for adults, and more care for Medicare patients, than any other specialists.

The ACP is a strong supporter of comprehensive health care reform because we believe the multifaceted problems of the current system must be addressed in an integrated fashion. It is critical that meaningful medical liability reform be a component of health reform legislation. We hope that today's hearing is a signal that you agree, and we appreciate the opportunity to present our recommendations.

Our nation's malpractice system does not work—for injured persons or physicians. Lawsuits are time-consuming and expensive for both sides, and many victims of negligence don't receive timely and adequate awards.

Physicians feel threatened by the potential for litigation and often believe they must perform procedures merely to protect themselves from liability. In a 1992 Gal-

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[18] O'Neil AC, Petersen LA, Cook EF, et al. *Physician reporting compared with medical-record review to identify adverse medical events.* Ann Intern Med 1993;119:370–376.

lup poll of general practice physicians, 93% of those surveyed said that the threat of medical liability suits causes them to order tests they might otherwise consider unnecessary. This risks harm to patients, causes the physician-patient relationship to suffer, adds to health care costs, and in some instances, hurts access to certain types of health care.

If defensive medicine adds only 5 percent to our nation's health care bill, that's $50 billion that we can ill afford. That money should be spent on appropriate care for sick patients—not on inappropriate care of potential litigants.

Mr. Chairman, today's malpractice system is arbitrary. The reasons why physicians get sued are unclear. Studies have shown that physicians are usually not sued when malpractice occurs, and are often sued when they are not at fault. This helps explain why physicians feel vulnerable in the current system, and often believe they must perform procedures to protect themselves from future legal action.

There is still no evidence to show a correlation between a physician's malpractice claims experience and quality of care. In fact, a study published in the most recent issue of the *Annals of Internal Medicine* showed that the reasons why patients contacted a malpractice attorney were primarily: general dissatisfaction with the health care system; television advertising by law firms; and their financial circumstances. While medical liability laws may be addressing certain needs of patients, they are not, and must not be seen as, a guarantor of quality of care.

As you know, the current tort system provides little protection for patients. Studies have shown that many more patients suffer an injury from negligence than file a malpractice claim. An even smaller percentage receive compensation. Moreover, those who do recover often must wait several years as the litigation crawls through the legal system.

We need a liability system that provides appropriate compensation for patients who are injured, with much smaller transaction costs than we now incur. We need a system that does not infect the physician-patient relationship with the looming threat that the two parties may end up in court. The reforms that we recommend are in the best interests of patients and physicians.

Medical malpractice reform will not solve all the problems in our nation's tort system. Nor will it necessarily end defensive medicine. However, it is a necessary first step that can help change the incentives in the system, thereby helping to restore the physician-patient relationship.

RECOMMENDATIONS

The ACP recommends a package of reforms based on the provisions of the California Medical Injury Compensation Reform Act (MICRA) including:

- **Cap on non-economic damages**—Caps on non-economic damages will ease physician fears of unlimited liability, and will reduce malpractice costs.
- **Elimination of joint and several liability**—This legal doctrine holds all defendants liable for the full award if any other defendants cannot pay their shares. It penalizes defendants who have to pay more than what would be warranted by their share of fault.
- **Offsets of awards from collateral sources**—Damage awards should be reduced by recoveries from other sources such as health insurance, disability insurance, and other sources.
- **Reasonable limits on statutes of limitations**—This will ensure that malpractice claims are reviewed in a timely way. Long statutes of limitations create uncertainty, delay, and expense.
- **Limiting attorney contingency fees**—Attorney contingency fees should be limited to less than 33 and 1/3% based on a sliding scale to decrease the incentive to seek excessive damages. In the *Annals* article noted earlier, attorneys cited the low estimate of award as the most frequent reason for not pursuing a malpractice case. The patient is at the mercy of the lawyer's potential revenue estimate. This is compelling evidence of the need for sliding scale limits on contingency fees, in order to reduce the financial incentive for lawyers to pursue high awards and refuse cases that they do not see as financially promising.

These tort reforms have been successful. They have caused malpractice premiums in California to decline from 1976 to 1991.

The effectiveness of caps on non-economic damages in reducing costs was recently affirmed by the U.S. Office of Technology Assessment. In its latest report, the OTA concluded that" the one reform consistently shown to reduce malpractice cost indicators is caps on [non-economic] damages."

Although these reforms have successfully reduced some malpractice costs, there is no evidence that they have reduced defensive medicine, the number of frivolous

suits filed, or the huge transaction costs associated with bringing a claim. Consequently, we urge adoption of other proposals:

Mandatory Binding Alternative Dispute Resolution—Strengthening alternative dispute resolution methods is a key component of reform since they can reduce the time and expense of litigation for both sides. Thus, it should be mandatory for litigants to go through ADR before bringing a case into court. Some jurisdictions have used mediation and early neutral evaluation techniques with success. Others prefer a more traditional approach such as arbitration.

Regardless of the method, we believe ADR will lead to settlements of disputes and reduce the time and expenses of full-blown litigation. The key to making it work, however, is that the ADR must be binding on the parties or provide a strong disincentive so plaintiffs do not go to court after the ADR is completed. An example would be the "English Rule" which requires a plaintiff to pay the defendant's legal costs if he receives a lesser award at trial than that available from the ADR.

Pretrial Screening—We urge the adoption of a provision requiring that, before a case can proceed, a screening panel comprised of attorneys and physicians review a plaintiff's case and determine if there was a probability of negligence and that the negligence caused the injury.

A strong pretrial screening mechanism will help prevent spurious claims from entering the system. Each state could design its own panel, but they should consist of physicians and attorneys. The decision of the panel should be allowed as evidence in any subsequent trial.

No-fault Demonstrations—We recommend federal support for demonstrations of no-fault malpractice systems such as use of Accelerated Compensation Events (ACEs). The College has long argued that we need to move away from an adversarial system to resolve malpractice claims, and toward a no-fault solution. Since proving fault is the basis of a lawsuit, if the plaintiff was not required to prove fault, it would save time and money for both sides. Of course, this type of system would also have to ensure that in return for a timely and definite compensation for injured patients, physicians would not be liable for non-economic damages.

Studies have shown that the use of ACEs and other methods to resolve disputes could be effective and save time. We believe it would be appropriate to fund demonstrations to determine the effectiveness of such programs.

IMPROVING QUALITY OF CARE

Mr. Chairman, most discussions of liability reform end up as shouting matches between doctors and lawyers. This prevents us from addressing the real issue—how to ensure that patients receive the highest quality care.

The malpractice system is ill-suited to perform this function. Its arbitrariness and lack of scientific foundation gives it no credibility with medical professionals. Its inability to provide timely and adequate compensation to injured persons creates cynicism and frustration for patients.

What we need is a new system to guarantee quality—a system that uses data to monitor physician practices and helps them improve their performance. Toward that end, the College supports a quality improvement system that uses data from practice profiles—of processes and outcomes—to measure quality. Use of this data in a system of ongoing quality improvement is the best way to ensure that patients get the best care.

Mr. Chairman, quality in medical care comes from professional imperatives to achieve excellence. It cannot be imposed externally, from government regulation or the tort system. The challenge is to design a system that fosters collaboration among physicians, hospitals, and health plans to improve quality, while simultaneously providing reasonable external review and consumer protection.

Physicians and health plans must take greater responsibility for the quality of the care they provide. When the data suggests a potential quality problem, it is the responsibility of the health plan and its practitioners to investigate the cause of the data variation and ultimately improve performance. If a particular physician is unwilling or unable to improve, the medical community must be willing to take appropriate action. Toward that end, state licensure boards must be given the necessary funding and authority to investigate and sanction physicians whose performance remains unsatisfactory.

Finally, Mr. Chairman, it should be noted that trends in the current health care system have exacerbated the need for liability reform. Specifically, insurance companies, through their "utilization review" procedures, have taken treatment decisions away from physicians. In addition, managed care organizations put pressure on physicians to more efficiently utilize resources, often by encouraging them to provide

fewer services. Insurers can enforce these rules by terminating their contracts with physicians.

At the same time, however, patients expect that physicians will do whatever is necessary for them, regardless of the cost. Patients can use the tort system to back them up.

Thus, physicians are caught in a "Catch 22." They can be fired for providing too much treatment, and sued for providing too little.

This issue was dramatically illustrated to you last week when Dr. Christine Cassel, the Chairman of the ACP Health and Public Policy Committee, testified before your committee regarding care at the end of life. As you recall, Dr. Cassel described how a physician's fear of being sued can create an adversarial environment that distorts the communication between the doctor and patient, just as they are making difficult but necessary treatment decisions.

In light of these considerations, we believe that tort reform becomes even more essential under the cross-pressures of managed care and other integrated systems. Beyond the reforms we have recommended, we urge further study of the concept of enterprise or organizational liability. While we recognize that past proposals in this area have their problems, it makes sense to us that, as we give health plans and networks the responsibility for providing care and for the quality of that care, we should also hold these organizations accountable for lapses in the quality of care. The concept deserves further exploration to determine whether it might be workable.

CONCLUSION

Mr. Chairman, we urge the Committee not to see the malpractice issue as a battle between physicians and patients. Most emphatically, the tort system does not provide adequate protection for patients who are injured during the course of medical care. Tort reform is at least as important for patients as it is for physicians. We hope that Congress and the advocacy groups who speak for consumers, as well as physicians, will view tort reform as a win-win issue for physicians, patients, and our health system as a whole, and come together on a significant package of reforms.

Thank you very much. I'll be happy to answer your questions.

PREPARED STATEMENT OF PHILIP H. CORBOY

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of proposals to increase access to health care. I am Philip H. Corboy, Chair of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1992, the ABA's House of Delegates reaffirmed its support of legislation calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The tort system has shown considerable resilience in the face of dramatic social and economic developments. State courts and legislatures are constantly working to improve the tort laws and should be permitted to continue to do so. Thus, federal intrusion into the field, with some discrete exceptions, is inappropriate.

The ABA believes that federal pre-emption of the state medical professional liability laws would constitute an unwise and unnecessary intrusion of major proportions on the longstanding authority of the states to promulgate tort law. Such pre-emption would cause the whole body of state tort law to become unsettled and create new complexities for the federal system. Unequal results would occur when medical professional liability litigation is combined with other fields of law with differing rules of law. An example of this would be a situation where a medical malpractice claim is joined with an automobile liability claim. If state tort laws differ from the federal law in areas such as caps on damages, the collateral source rule or joint and several liability, conflicts and uncertainty would likely result; and one defendant in an action could well be treated entirely differently than another. Having one set of rules to try medical professional liability cases and another set of rules to try other tort cases is not consistent with the sound and equitable administration of justice.

Our ABA policies reflect the ABA's recognition that the issue of medical professional liability is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are especially concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants—in this case, the medical profession. It is the ABA's belief that the rights of injured persons to recoverfully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals, that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

WHAT IS THE COST OF THE MEDICAL-LEGAL SYSTEM?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

- Reliance on modern, sophisticated and expensive treatment.
- Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- An aging population, which adds to Medicare and Medicaid expenditures;
- High administrative costs of the health care system; and
- The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant. The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.(1) I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."(2)

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.(3) That uncertainty has resulted in the inability to statistically measure the cost.(4) In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.(5) Some have considered the cost of new technology and advancements in medical knowledge, care and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.(6) When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.(7) Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

Because no reliable studies have been done to estimate the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study in 1994.

HAVE TORT PROPOSALS, WHEN ENACTED, LOWERED OVERALL HEALTH CARE COSTS?

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower health care costs for everyone. In general, these types of proposals have been enacted only within the last ten years. Insufficient time has elapsed, and insufficient data has been gathered to enable us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. We developed a chart (attached as Appendix C) showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending

Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

As the chart demonstrates, personal health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average—Arkansas, Kentucky and Mississippi—had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

Our findings are consistent with other studies. For example, in March 1993, the Coalition for Consumer Rights published *False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs.* This study found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."(8) Regarding caps on damages, the Coalition's study concluded as follows:

> Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is *no correlation* between the least expensive states and limits on damages.
>
> Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.

A 1992 study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas.

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have been relatively stable in recent years. The number of medical malpractice claims peaked in 1985, and has continued to decline according to the most current figures available. From 1985 to 1990, the overall rate declined at an average annual rate of 8.9 per cent.

WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public—injured persons of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

SHOULD ALTERNATIVE DISPUTE RESOLUTION BE INCLUDED IN A NATIONAL HEALTH ACCESS PROPOSAL?

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, Minnesota. The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?," and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; how ever, during the past 16 years, the ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation's dispute resolution agenda. The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different. Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the *ABA Blueprint for Improving the Civil Justice System.* Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after suit is filed, as welcome components of the justice system. (Adopted August 1989.)
2. Consistent with the attached ABA policy (Appendix D), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)
3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)
4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators—an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation. Voluntary alternative dispute resolution, for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation with alternative dispute resolution techniques both before and after

suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected. Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less expensive and less stressful than seeing a case through its normal trial path.

Thank you for giving us this opportunity to present our views to you.

ENDNOTES

1 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

2 Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (October 1992) page 27.

3 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care. " Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.

4 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." *Physician Payment Review Commission 1991 Annual Report to Congress, page 374.*

5 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities—Joint Ventures in Radiation Therapy, *The New England Journal of Medicine,* Vol. 327, No. 21, Nov. 19, 1992, pages 1497–1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," *The New England Journal of Medicine,* Vol. 327, No. 21 Nov. 19, 1992, pages 1502–1506.

6 Patricia M. Danzon, "Liability for Medical Malpractice," *Journal of Economic Perspectives,* Vol. 5, No. 3, Summer 1991, pages 51–69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

- Physicians and hospitals often benefit financially by delivering more care.
- Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.
- So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

7 Testimony, Robert D. Reischauer, Director, Congressional Budget Off ice, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

8 *Andrea Dubin,* False Claims: The Relationship between Medical Malpractice "Reforms" and Health Care Costs, *prepared for the Coalition for Consumer Rights, March 1993, at Page 2.*
9 Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.
10 1989 Profitability Study (By Line By State) *1990 Profitability Study (By Line By State), 1991, Profitability Study (By Line By State), 1992 Profitability Study, (By Line By State),* National Association of Insurance Commissioners, 1990, 1991, 1992 and 1993.
11 Martin L. Gonzalez "Medical Professional Claims and Premiums 1985–1990," *Socioeconomic Characteristics of Medical Practice* 1992, page 23.

APPENDIX A.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 11, 1986

Be It Resolved, That

(1) The American Bar Association urges appropriate ABA entities. such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism. to continue to consult. where appropriate. with representatives of the American Medical Association and others in the health care industry. the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The legal and medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

(2) Consistent with these goals. the American Bar Association adopts the following principles:

a. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

b. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

c. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

d. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

e. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

f. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

g. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

h. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

i. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

j. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

k. The use of structured settlements should be encouraged.

l. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

APPENDIX B.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 123)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A. Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to assure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

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In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested programs for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

H. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

APPENDIX C.

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office. May 1993. Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).

Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
1 Massachusetts	$1,508	$3,031	101
2 California	1,451	2,894	99
3 New York	1,417	2,818	99
4 Nevada	1,380	2,757	100
5 Rhode Island	1,351	2,707	100
6 Connecticut	1,348	2,699	100
7 North Dakota	1,325	2,661	101
8 Illinois	1,308	2,619	100
9 Missouri	1,285	2,568	100
10 Michigan	1,281	2,569	101
11 Pennsylvania	1,273	2,536	99
12 Kansas	1,271	2,548	100
13 Ohio	1,247	2,493	100
14 Maryland	1,232	2,436	98
15 Minnesota	1,229	2,480	102
16 Hawaii	1,228	2,469	101
17 Florida	1,228	2,427	98

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18 Wisconsin	1,219	2,449	101
19 Nebraska	1,216	2,452	102
20 Colorado	1,209	2,415	100
21 Alaska	1,187	2,367	99
22 Iowa	1,176	2,351	100
23 Washington	1,165	2,311	98
24 Oregon	1,165	2,312	98
25 South Dakota	1,154	2,322	101
26 Delaware	1,153	2,268	97
27 Tennessee	1,144	2,262	98
28 New Jersey	1,115	2,224	99
29 Arizona	1,112	2,211	99
30 Texas	1,110	2,192	97
31 Louisiana	1,106	2,185	98
32 Indiana	1,101	2,201	100
33 Maine	1,091	2,175	99
34 Oklahoma	1,086	2,139	97
35 West Virginia	1,057	2,088	98

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
36 Virginia	1,054	2,076	97
37 Georgia	1,048	2,072	98
38 Montana	1,036	2,059	99
39 Alabama	1,033	2,286	121
40 Arkansas	994	1,944	96
41 New Hampshire	986	1,981	101
42 Vermont	978	1,956	100
43 Kentucky	957	1,875	96
44 North Carolina	931	1,833	97
45 New Mexico	904	1,792	98
46 Mississippi	897	1,751	95
47 Utah	896	1,784	99
48 Wyoming	873	1,756	101
49 Idaho	868	1,726	99
50 South Carolina	857	1,689	97
U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged $2,255.*

** *Rounded off to the nearest whole number.*

AMERICAN BAR ASSOCIATION
GOVERNMENTAL AFFAIRS OFFICE
1800 M STREET, N.W.
WASHINGTON, D.C. 20036

May 13, 1994

The Honorable Daniel P. Moynihan
Chairman
Committee on Finance
United State Senate
Washington, DC 20510-6200

Dear Mr. Chairman:

At your Committee's hearing on medical malpractice, yes day, you requested me to supply for the record of the hear the following information (and enclosures):

1. Excerpts documenting state medical malpractice "reforms from the Office of Technology Assessment publication dated September 1993 and titled "Impact of Legal Reform on Medical Malpractice Costs," and from the American Medical Association publication dated 1989, entitled "AMA Tort Reform Compendium."

2. Also, sources for my comments on obstetricians/ gynecologists: Physicians enter the field of obstetrics in large numbers and obstetricians continue to maintain a profitable field of practice. The mean-net income of obstetricians/gynecologists, after expenses (including liability premiums) and before taxes, was $207,300 in 1990. The percent of obstetrician/gynecologists who incur claims annually dropped at an average annual rate of 22.7 percent between 1985 and 1990. (The source of this information is Martin L. Gonzalez, "Medical Professional Liability Claims and Premiums, 1985-90," Socio-economic Characteristics of Medical Malpractice 1992, published by the American Medical Association, at pages 24 and 132.) To become a recognized obstetrician/ gynecologist, a person with a medical degree becomes certified by the American Board of Obstetrics and Gynecology. Before 1980, there were 18,663 board certified obstetrician/gynecologists. In the period between 1980 and 1989, 10,153 new obstetrician/gynecologists received certificates. As of July 1991, there were 25,043 board certified physicians obstetrician/ gynecologists. (This information is from the ABMS Compendium of Certified Medical Specialists, 3rd Edition, 1990-91, Vol.1, at page vii, published by the American Board of Medical Specialties; 1991 ABMS Compendium Supplement, at page viii.)

In addition, I would like to elaborate on your question concerning whether there should be some sort of sanction against a plaintiff who rejects an award in binding mandatory arbitration, then proceeds to trial and receives substantially less in a court award then he or she would have received had he or she accepted the arbitration award. As I said to you yesterday, I have no problem with coming up with an appropriate sanction provided there was also an appropriate sanction for the defendant as well. You then asked whether the shifting of attorneys' fees against a plaintiff -- if at trial he or she receives less than the award -- would be appropriate. I said a plaintiff who lost in the ordinary course of events would probably be judgment proof, and such a sanction meaningless. I would like to add that the shifting of attorneys' fees and other substantial financial incentives, which may penalize a decision to reject a settlement offer and proceed to trial, would appear to be inconsistent with the American Bar Association policy of protecting every disputant's legal rights and remedies. In August 1989, the ABA adopted the following policy:

> RESOLVED, That the American Bar Association supports continued use of and experimentation with "alternative" dispute resolution techniques, both before and after suit is filed, as necessary and welcome components of the justice system in the United States. These dispute resolution techniques include early neutral evaluation, mediation, arbitration, summary jury trials and minitrials. All "alternative" dispute resolution techniques should assure that every disputant's constitutional and other legal rights and remedies are protected.

Thank you for giving me the opportunity to appear before your Committee. I hope my testimony was helpful to the Committee. Please let me know if the ABA can provide you with additional information.

Sincerely,

Philip H. Corboy

Enclosures

cc: Members of the U.S. Senate
Committee on Finance
Lillian B. Gaskin

AMA TORT REFORM COMPENDIUM

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1989

AMA Tort Reform Compendium
Tort Reforms Currently in Effect

State	Ad Damoum Clause	Arbitration	Attorney Fee Regulation	Collateral Source Rule	Frivolous Lawsuit Penalties	Joint & Several Liability Rule	Limits on Recovery	Patient Compensation Funds	Periodic Payment of Damages	Pretrial Screening Panels
Alabama	x	x		x			x		x	
Alaska	x	x		x		x	x		x	x
Arizona	x		x	x		x			x	
Arkansas	x				x				x	
California	x	x	x	x		x	x		x	
Colorado	x	x		x	x	x	x		x	x
Connecticut	x		x	x		x			x	x
Delaware			x	x					x	x
Florida	x	x	x	x		x	x		x	x
Georgia	x	x		x	x	x				
Hawaii	x		x		x	x	x			x
Idaho	x				x	x	x		x	x
Illinois	x	x	x	x	x				x	
Indiana	x		x	x	x		x	x	x	x
Iowa	x		x	x	x				x	
Kansas	x		x	x	x		x	x	x	x
Kentucky	x			x		x				
Louisiana	x	x					x	x	x	x

AMA Tort Reform Compendium
Tort Reforms Currently in Effect

State	Ad Damnum Clause	Arbitration	Attorney Fee Regulation	Collateral Source Rule	Frivolous Lawsuit Penalties	Joint & Several Liability Rule	Limits on Recovery	Patient Compensation Funds	Periodic Payment of Damages	Pretrial Screening Panels
Maine	x		x						x	x
Maryland	x		x				x		x	x
Massachusetts	x		x	x	x		x			x
Michigan		x	x	x	x	x	x		x	x
Minnesota				x	x	x	x		x	
Mississippi	x				x	x				
Missouri	x					x	x		x	
Montana				x	x	x			x	x
Nebraska	x		x	x	x		x	x		x
Nevada						x				x
New Hampshire	x		x		x		x			x
New Jersey			x	x	x	x				x
New Mexico	x					x	x	x	x	x
New York	x	x	x	x	x	x			x	x
North Carolina	x				x					
North Dakota				x	x	x			x	
Ohio	x	x		x	x	x	x		x	x
Oklahoma	x		x		x					

AMA Tort Reform Compendium
Tort Reforms Currently in Effect

State	Ad Damnum Clause	Arbitration	Attorney Fee Regulation	Collateral Source Rule	Frivolous Lawsuit Penalties	Joint & Several Liability Rule	Limits on Recovery	Patient Compensation Funds	Periodic Payment of Damages	Pretrial Screening Panels
Oregon	x		x	x	x	x	x			
Pennsylvania								x		
Rhode Island	x			x	x				x	
South Carolina					x			x	x	
South Dakota		x		x	x	x	x		x	
Tennessee	x		x	x						
Texas	x				x	x				
Utah	x	x	x	x	x	x	x		x	x
Vermont		x								
Virginia		x					x			x
Washington	x		x	x		x			x	
West Virginia	x					x	x			
Wisconsin	x		x				x	x	x	
Wyoming			x		x	x				x

IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS

Background Paper
prepared by the

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September 1993

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EXPLANATION OF METHODS USED BY OTA TO COMPILE DATA

The tables, figures, and accompanying notes in appendix A were derived from a variety of sources and synthesized by OTA to reflect the most recent information available on selected State medical malpractice reforms.

The primary published sources were 1991 and 1993 editions of a compendium developed for the Federal Agency for Health Care Policy and Research (AHCPR),[1] selected State statutes, and judicial cases. Two additional sources were used to update, cross-check, and supplement the AHCPR compendia.[2]

After compiling information from these sources into summary tables, OTA sent draft copies of the information to the attorneys general in all 50 States on March 24, 1993, for confirmation or amendment. Information was changed to reflect respondents' comments. Where conflicts arose between the attorney general response and information found elsewhere, the attorneys general's responses were favored. Unresolved questions were addressed through follow-up phone conversations with attorney general respondents and statutory research. The revised drafts were sent again to all 50 State attorneys general on June 25, 1993, for a final review and any corrections were incorporated.

For States that responded to the first survey only, information is current to March 1993. For States that responded to the second survey, information is current to June 1993. For the 10 States[3] that did not respond to either review and the District of Columbia, information was cross-checked and supplemented through followup telephone calls and/or review of the relevant State codes where possible. Where confirmation was not possible, information in this appendix reflects that presented in the 1993 edition of the AHCPR compendium.

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[1]U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, "Compendium of State Systems for Resolution of Medical Injury Claims," prepared by S.M. Spernak, Center for Health Policy Research, The George Washington University (Rockville, MD: AHCPR, April 1993), AHCPR Pub. No. 93-0053; U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, "Compendium of State Systems for Resolution of Medical Injury Claims," prepared by S.M. Spernak and P.P. Budetti, Center for Health Policy Research, The George Washington University (Rockville, MD: DHHS, February 1991), DHHS Pub. No. (PHS)91-3474.

[2]These sources were: Fisk, M.C., "The Reform Juggernaut Slows Down," The National Law Journal 15(10):1,34-37, Nov. 9, 1992; American Nurses Association, "Report to ANA Board of Directors on Tort Reform, Part 3: Presentation of Selected Summary of State and Local Legislation Related to Tort Reform and Review of Insurance Company Practices and Policies Related to Nursing Negligence with Recom-mendations," December 1991.

[3]DE,FL,HI,KS,KY,MS,NJ,NM,TX,WV.

Table A-1—Collateral Source Offset Provisions,[a] by State, 1993

Mandatory	Discretionary	No provision
CO*	AK*	AR
CT	AL	DC
FL	AZ	GA[O]
IA	CA	HI
IL*	DE	LA
ID	IN	MO*
KS[O]*	KY	MS
MA*	MD*	NC
ME	ND[O]*	NE
MI	OR	NH[O]
MN*	SD	NV*
MT*		OK
NJ		PA[O]
NM		SC
NY		TX
OH*		VA
RI*		VT
TN		WA*
UT		WI
		WV
		WY

[a]The traditional collateral source rule forbade evidence of the plaintiff's collateral sources of income and reimbursement (e.g., medical insurance, disability payments) from being entered into evidence. States classified as "mandatory" or "discretionary" in this table have modified the traditional evidence rule to allow certain types of collateral sources to be admitted as evidence. Statutes which require that the plaintiff's award be offset by certain collateral sources are classified as mandatory. Statutes that leave the decision of whether to offset to the jury or judge are classified as discretionary. States with no provision have not modified their traditional collateral source rules. It is of note that a number of States reduce the malpractice award by the collateral source payments, but credit the plaintiff with any premiums he or she has paid or will pay to obtain the insurance (e.g., MN, MI, CT, RI, IL and NY).

O = Provision overturned.

* See additional notes on following pages.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-1

Cases Overturning Collateral Source Offset Rules:

Georgia--Denton v. Con-Way Southern Express Inc., 402 S.E.2d 269 (Ga. 1991) (statute mandating evidence of collateral sources violates guarantee of impartial and complete governmental protection).

Kansas--see explanation below.

New Hampshire--Carson v. Maurer, 424 A.2d. 825 (N.H. 1980).

North Dakota--Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978) held an earlier statute for collateral source offsets unconstitutional.

Pennsylvania--The Pennsylvania Supreme Court struck down as unconstitutional the State statute providing for pretrial screening panels. The collateral source provision was a part of that statute and was nullified. Mattos v. Thompson 421 A.2d. 190 (1980).

Selected Additional Information:

Alaska--Collateral source offset determined by the court (Alaska Stat. Supp. Secs. 9.55.548; 9.17.070 (1992)).

Colorado--Collateral source offset determined by the court (Colo. Rev. Stat. Sec. 13-64-402 (1992)).

Illinois--Reduction of collateral source is for 50 percent of collateral payments for lost wages or disability benefits and 100 percent of medical benefits (with exceptions), but no more than 50 percent of the total verdict (735 ILCS 5/2-1205 (West 1992)).

Kansas--When claimant demands $150.000 or more, evidence of collateral sources admissible. Reduction of award by collateral source amount is subject, however, to certain limitations (KSA Secs. 60-3801 - 3807 (Supp. 1992)). This statute applies to all personal injury suits. The original statute abrogating collateral source for medical malpractice suits only was struck down (Farley v. Engelken 740 P.2d 1058 (1987)). Also, in Wentling v. Medical Anesthesia Services, P.A., 701 P.2d 939 (Kan. 1985), court held that collateral source offsets were unconstitutional in wrongful death medical malpractice cases.

Maryland--An award of damages by a medical malpractice arbitration panel may be reduced by the amount of damages reimbursed by certain collateral sources (Md. Cts. & Jud. Proc. Code Ann. Sec. 3-2A-05(h) (Michie 1989)). (See table A-5 and Additional Notes to table A-5 for description of Maryland's arbitration panel provision.)

Massachusetts--Collateral source offset determined by the court (Mass. Gen. Laws Ann. ch. 231, Sec. 60G (Lexis 1992)).

Minnesota--Offset is mandatory if defendant brings in evidence of payments made to plaintiff by collateral sources (Minn. Stat. Sec. 548.36 (1992)).

Missouri--Damages paid by defendant (or his insurer or any authorized representative) prior to trial may be introduced as evidence. Such introduction shall constitute a waiver of any right to a credit against a judgment (R.S.Mo. Sec. 490.715 (1991)).

Montana--Collateral offset determined by judge after jury verdict (Mont. Code Ann. Sec. 27-1-308 (1992)).

Nevada--In actions against providers of health care, damage awards must be reduced by the amount of any prior payment made by health care provider to the injured person or claimant to meet reasonable expenses and other essential goods or reasonable living expenses (Nev. Rev. Stat. Sec. 42.020 (Supp. 1991)).

ADDITIONAL NOTES FOR TABLE A-1 (Continued)

North Dakota--Under North Dakota law, collateral source "does not include life insurance, other death or retirement benefits, or any insurance or benefit purchased by the party recovering economic damages" (N.D.C.C. Sec. 32-03.2-06 (Lexis 1991). (An earlier collateral source offset provision was overturned in the courts--see above.)

Ohio--Collateral sources do not include insurance benefits paid for by plaintiff or employer (Ohio Rev. Code Ann. Sec. 2305.27 (Baldwin 1992)).

Rhode Island--Collateral source is mandatory if evidence is admitted (R.I. Gen. Laws Sec. 9-19-34 (1992)).

Washington--Washington's statute allows information on collateral source to be entered into trial, except the collateral source rule excludes insurance purchased by the plaintiff or insurance purchased by the employer for the plaintiff (RCW Sec. 7.70.080). However, offset of collateral sources is governed by case law, and in practice there is no offset for collateral sources. See Sutton v. Shufelberger, 643 P.2d 920 (Ct. App. Wash. 1982); Bowman v. Whitelock, 717 P.2d. 303 (Ct. App. Wash. 1986).

SOURCE: Office of Technology Assessment. 1993.

Table A-2--Caps on Damages[a] and State Patient Compensation Funds, by State, 1993

Noneconomic cap	Economic and noneconomic	No statutory limits	PCF (Patient Compensation Fund)
AK: $500,000*	AL:[O] Total recovery capped at $1 million.*	AR	FL: Physicians may participate in fund by obtaining liability coverage of $250,000 per claim and $500,000 per occurrence. Fund will pay malpractice awards exceeding maximum physician liability of $250,000 per claim, up to $1 million per claim and $3 million aggregate per policy.
CA: $250,000		AZ	
FL:[O] $350/250,000	CO: Total recovery capped at $1 million. $250,000 cap on noneconomic.*	CT	
HI: $375,000		DC	
ID:[O] $400,000*		DE	
KS:[O] $250,000*	IN: $750,000	GA	
MD: $350,000	LA: $500,000*	IA	
MA: $500,000	NE: $1,250,000	IL[O]	IN: Provider not liable for that portion of any malpractice award which exceeds $100,000. Any amount due the plaintiff which is in excess of the total liability of all health care providers, shall be paid from the PCF, with total payments from the PCF not to exceed $750,000.
MO: $465,000*	NM: $500,000*	KY	
OR: $500,000	SD: $1,000,000*	ME	
UT: $250,000	VA: $1,000,000	MN[R]	
WV: $1,000,000		MS	
WI: $1,000,000		MT	
		NC	
		*ND[O]	
		NH[O]	
		NJ	
		NV	
		NY	
		OH[O]	
		OK[R]	
		PA	
		RI	KS: Physicians must carry $200,000 in malpractice insurance per claim ($600,000 per annum) then can choose one of three options for excess coverage from PCF. For each, option, the physician pays the initial $200,000 in damages and then the fund will pay some portion of the remainder depending on how the physician chooses to distribute fund liability across potential claims: 1) fund liable for next $100,000 per claim ($300,000 aggregate per provider); 2) fund liable for next $300,000 ($900,000 aggregate per provider); and 3) fund liable for up to $800,000 per claim.
		SC	
		TN	
		*TX[O]	
		VT	
		WA[O]	
		WY	

Table A-2–Caps on Damages[a] and State Patient Compensation Funds, by State, 1993 (Continued)

Noneconomic cap	Economic and noneconomic	No statutory limits	PCF (Patient Compensation Fund)
			LA: Provider liability limited to $100,000 for injuries or death to plaintiff. Fund will pay total amount recoverable for all injuries or death of a plaintiff exclusive of future medical care and related benefits, up to $400,000 for private providers. The State pays all damages up to $500,000 for State health care providers.
			NE: The PCF shall cover liability exceeding $200,000 up to $1.25 million.
			NM: Health care provider liability is capped at $100,000, with the remainder to be paid by the PCF. Total payment from PCF not to exceed $500,000 per occurrence per year.
			PA: The fund shall pay any amount exceeding $100,000 per occurrence, up to $1 million per claim.
			SC: The fund will pay awards in excess of $100,000 per claim (no upper limit).
			WI: Physicians must have $400,000 of malpractice coverage per incident and $1,000,000 in coverage per annum. The fund will pay for damages exceeding the physician's coverage. Each health care provider is also assessed an annual fee to help finance the fund.

[a]NOTE: OTA's review did not include caps that apply only, or separately, to claims against State-employed or State-owned health care providers.

O = Provision overturned.
R = Provision repealed.

*See additional notes on following pages.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-2

Cases Overturning Caps on Damages:

Alabama--Moore v Mobile Infirmary, 592 So.2d 156 (Ala. 1991) ($400,000 cap on noneconomic and punitive damages overturned, but $1 million cap on total recovery not challenged--see notes below).

Florida--Smith v Department of Insurance, 507 So.2d 1080 (Fla. 1987).

Idaho--Jones v. State Board of Medicine 555 P.2d 399 (Idaho 1976) *cert denied* 431 U.S. 914 (1977).

Illinois--Wright v. Central DuPage Hospital, 347 N.E.2d 736 (Ill. 1976).

Kansas--Kansas Malpractice Victims Coalition. v. Bell, 757 P.2d 251 (Kan. 1988) (cap on total damages and noneconomic damages in medical malpractice cases overturned).

New Hampshire--Brannigan v Usitalo, 587 A.2d 1232 (N.H. 1991).

North Dakota--Arneson v. Olson, 270 N.W.2d. 125 (N.D. 1978).

Ohio--Morris v. Savoy, 576 N.E.2d 765 (Ohio 1991).

Texas--Lucas v. U.S., 757 S.W.2d 687 (Tex. 1988); Baptist Hospital of S.E. Texas v Barber, 672 S.W.2d 296 (Tex. App. 1984), *aff'd.* 714 S.W.2d 310 (Tex. 1986).

Washington--Sophie v Fibreboard Corporation, 771 P.2d 711 (Wash. 1989).

Selected Additional Information:

Alabama--Total recovery in medical malpractice cases must not exceed $1 million. If jury returns a verdict in excess of $1 million, judge must reduce it to $1 million or lesser amount as deemed appropriate. Mistrial declared if jury is informed of cap beforehand. Total cap is adjusted annually to reflect changes in the consumer price index. (Ala. Rev. Stat. Sec. 6-5-547 (1987)) Separate cap on noneconomic damages was overturned (see above).

Alaska--Limit does not apply to damages for disfigurement or severe physical impairment (Alaska Stats. Supp. Sec. 9.17.010 (1992)).

Colorado--Court has some discretion to exceed cap limit (Colo. Rev. Stat. Sec. 13-64-302 (1992)).

Florida--In arbitration, noneconomic damages limited to $250,000 per incident. Economic damages limited to 80 percent of wage loss and loss of earning capacity and medical expenses, offset by collateral sources. If defendant refuses to arbitrate, the claim will proceed to trial and there will be no limit on damages. In addition, if plaintiff wins at trial, she will be awarded prejudgment interest and attorney fees up to 25 percent of award. If claimant rejects arbitration, noneconomic damages at trial limited to $350,000. Economic damages limited to 80 percent of wage losses and medical expenses (Fla. Stat. Secs. 766.207-209 (1993 Supp.)). This provision was recently challenged. The trial court found the provision unconstitutional, as did the District Court of Appeals. However, the Supreme Court of Florida reversed holding the limitation on damages imposed if the plaintiff does not accept arbitration is not unconstitutional. University of Miami v. Echarte, 585 So.2d 293 (Fla. App. 3 Dist. 1991) *reversed and remanded* University of Miami v. Echarte, 618 So.2d 189 (Fla. 1993).

Idaho--Original cap applied to malpractice suits only and was overturned (see above). Existing cap applies to all torts. Cap increases or decreases yearly ac-

ADDITIONAL NOTES FOR TABLE A-2 (Continued)

cording to the State's adjustment of the average annual wage (Idaho Code Sec. 6-1603 (Lexis 1993)).

Kansas--Original cap for malpractice suits only was overturned (see above). Existing cap applies to all personal injury suits.

Louisiana--The total amount of damages for a medical malpractice claim against a "qualified provider" may not exceed $500,000, plus interest and costs, exclusive of future medical care and related benefits. Qualification under the patient compensation fund requires a private health care provider to pay into the fund and provide evidence of insurance up to $100,000 per claim. "Qualified providers" exclude State health care providers. For qualified providers, the provider is liable for up to $100,000 and the State patient compensation fund for the remaining amount not to exceed $400,000 exclusive of future medical care and related benefits. For State health care providers, total damages, exclusive of future medical care and related benefits, may not exceed $500,000 (LA-R.S. Sec. 40:1299.42-45; LA-R.S. Sec. 40: 1299.39-39.1) Future medical expenses and related benefits in excess of $500,000 are paid as submitted.

Massachusetts--Pain and suffering capped at $500,000 unless there is substantial or permanent loss or impairment of bodily function or substantial disfigurement or other circumstances making limitation unfair (Mass. Gen. Laws Ann. ch. 231, Sec. 60H (Lexis 1992)).

Michigan--Noneconomic damages limited to $225,000 unless there has been a death, intentional tort, injury to reproductive system, foreign body wrongfully left inside the patient's body, concealment of injury by health care provider, limb or organ wrongfully removed or patient has lost vital bodily function. The limit on damages increases each year by the increase in Consumer Price Index (M.C.L. Sec. 600.1483 (1990)). The exceptions to the cap are so extensive that, as of August 1993, the cap had yet to be applied to a single case (154).

Missouri--Noneconomic damages recoverable by injured party capped at $465,000 per defendant per occurrence (1993 limit). Original limit was $350,000, but this is adjusted annually to reflect changes in the implicit price deflator for personal consumption published by the U.S. Department of Commerce (R.S.Mo., Sec. 538.210 (1986)).

New Mexico--The limitation on caps on damages does not apply to past and future medical care and related benefits (N.M. Stat. Ann. Sec. 41-5-6, 41-5-7 (Michie 1989)). These expenses will be paid on an ongoing basis. In 1995, the cap on damages will be increased to $600,000 and the Patient Compensation Fund will require the physician to be responsible for the first $200,000 of a malpractice claim (N.M. Stat. Ann. Sec. 41-5-6 (Michie 1989)).

North Dakota--Awards in excess of $250,000 may be reviewed for reasonableness (N.D. C.C. Sec. 32-03.2-08 (Lexis 1991)).

South Dakota--South Dakota s medical malpractice cap is currently being challenged in the court on constitutional grounds (Schultz, J.S., Legal Counsel, Division of Administration, Office of Administrative Services, Department of Health, South Dakota, letter to the Office of Technology Assessment, U.S. Congress, Washington, DC, April 2, 1993).

Texas--The $500,000 limit on damages in medical malpractice (Vernon's Texas Civil Stat. Art. 4590i, Sec. 16.02-11.03 (Supp. 1992)) was struck down as unconstitutional in Lucas v. U.S., 757 S.W.2d 687 (Tex. 1988). The Texas Supreme Court subsequently decided that the damage limitation was constitutional in wrongful death cases only (Rose v. Doctors Hosp., 801 S.W.2d 841 (Tex. 1990)).

SOURCE: Office of Technology Assessment, 1993.

Table A-3--Periodic Payment of Awards,[a] by State, 1993

Mandatory	Discretionary	No provision
AL > $150,000*	AK*	DC
AZ	AR > $100,000	GA
CA > $50,000	CT > $200,000*	HI
CO > $150,000	DE	KS[O]
IL > $250,000*	FL > $250,000	KY
LA ≥ $500,000*	IA	MA
ME ≥ $250,000	ID > $100,000	MS
MI	IN	NC
MO > $100,000*	MD	NE
NM	MN > $100,000	NH[O]
OH > $200,000	MT > $100,000	NJ
SD > $200,000	ND*	NV
UT > $100,000	NY > $250,000*	OK
WA > $100,000*	OR	PA
	RI > $150,000*	TN
	SC > $100,000	TX
		VA
		VT
		WI
		WV
		WY

[a]Periodic payment provisions are often not triggered unless the award reaches a threshold amount. The specific thresholds are noted parenthetically in the table. Periodic payment provisions apply only to future damages. The schedule of payments is either negotiated by the parties or determined by the court. Some statutes offer guidelines for determining the schedule. The mandatory category includes statutes in which periodic payment is mandatory upon reaching the threshold or upon unilateral request by defendant or plaintiff.

O = Provision overturned.

* See additional notes on following page.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-3

Cases Overturning Periodic Payment Provisions:

Kansas--Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988).

New Hampshire--Carson v. Maurer, 424 A.2d 825 (N.H. 1980).

Selected Additional Information:

Alabama--A recent Alabama Supreme Court case overturned a periodic payment provision that applied to personal injury suits, excluding malpractice. This provision was similar to the medical malpractice periodic payment provision, thereby calling its constitutionality into question (Clark v. Container Corp., 589 So.2d 184 (Ala. 1991)).

Alaska--Periodic payment of future damages is discretionary in personal injury cases except if requested by injured party (Alaska Stat. Supp. Sec. 09.17.040 (1992)).

Connecticut--When award reaches $200,000 or more, parties have 60 days to negotiate periodic payment agreement. If no agreement reached, a lump sum award will be awarded (Conn. Gen. Stat. Sec. 52-225d).

Florida--Mandatory periodic payment of future losses exceeding $250,000, but defendant may elect to pay lump sum for future economic loss and expenses, reduced to future present value (Fla. Stat. Sec. 766.78 (1986)).

Illinois--Both parties can agree to elect periodic payment, or, if future damages exceed $250,000, plaintiff can unilaterally elect periodic payment. Defendant can elect periodic payment if: 1) the future economic damages are in excess of $250,000, 2) defendant can produce a security (e.g. bond, annuity) in the amount of the claim for both past or future damages, or $500,000, whichever is less, and 3) future damages likely to occur over a period of more than one year (735 ILCS Sec. 5/2-1705 (West 1992)).

Louisiana--If damages exceed $500,000, the PCF or the State pays future medical care and related benefits as they are submitted. (See table A-2 for a description of Louisiana s cap on damages provision.)

Missouri--Mandatory periodic payment of future damages at request of any party (R.S.Mo. Sec. 538.220, (1991)).

New York--Any requirement to pay periodically applies to no more than the portion of future damages in excess of $250,000. The parties may agree to lump sum payments of future damages otherwise payable periodically (N.Y. CPLR Sec. 5031 (McKinney 1992)).

North Dakota--The court has discretion to permit the trier of fact to make a special finding regarding future economic damages if an injured party claims future economic damages for continuing institutional or custodial care that will be required for a period of more than two years (N.D.C.C. Sec. 32-03.2-09 (1989)).

Rhode Island--Mandatory conference for purposes of determining viability of voluntary agreement for periodic damage (R.I. Gen. Laws Secs. 9-21-12; 9-12-13 (Lexis 1991)).

Washington--Mandatory at the request of parties (Wash. Rev. Code Sec. 4.56.260 (1986)).

SOURCE: Office of Technology Assessment, 1993.

Table A-4--Statutes of Limitations,[a] by State, 1993

	Years within date of injury	Years within date of discovery	Maximum number of years	Foreign object exception**
AL:	2 years	6 months	4 years	-
AK:	-	*2 years	-	-
AR:	2 years	-	-	1 year
AZ:	-	2 years	-	-
CA:	3 years	1 year	3 years	1 year
CO:	-	2 years	3 years	2 years
CT:	-	2 years	3 years	-
DC:	3 years	-	-	-
DE:	2 years	3 years	-	-
FL:	2 years	2 years	4 years	-
GA:	2 years*	-	5 years	1 year
HI:	-	2 years	6 years	-
ID:	2 years	-	-	1 year*
IN:	-	2 years	-	-
IL:	-	2 years	4 years	-
IA:	-	2 years	6 years	2 years
KS:	-	2 years	4 years	-
KY:	-	1 year	5 years	-
LA:	1 year*	1 year	3 years	-
MA:	3 years	-	7 years	General Exception
ME:	3 years	-	3 years	Upon "reasonable discovery"
MD:	5 years	3 years	-	Exception for minors only
MI:	2 years*	6 months	6 years	6 months
MN:	2 years*	-	-	-
MS:	-	2 years	-	-
MO:	-	2 years	10 years	2 years after discovery 10 years max.
MT:	3 years	3 years	5 years	-
NE:	2 years	1 year	10 years	-
NV:	4 years	2 years	-	-
NH:	3 years	3 years	-	-
NJ:	-	2 years*	-	-
NM:	3 years*	-	-	-
NY:	2 years, 6 months	-	-	1 year
NC:	3 years	-	4 years	1 year after discovery, 10 year max
ND:	-	2 years	6 years	-
OH:	-	1 year	-	-
OK:	-	2 years	3 years O*	-
OR:	-	2 years	5 years	-
PA:	2 years	2 years	-	-
RI:	3 years	3 years	-	-
SC:	3 years	3 years	6 years	2 years
SD:	2 years	-	-	-
TN:	-	1 year	3 years	1 year
TX:	2 years*	-	-	-
UT:	-	2 years	4 years	1 year

Table A-4—Statutes of Limitations,[a] by State, 1993 (Continued)

Years within date of injury	Years within date of discovery	Maximum number of years	Foreign object exception**
VT: 3 years	2 years	7 years	2 years
VA: 2 years	-	10 years	1 year
WA: 3 years	1 year	8 years	1 year
WV: 2 years	2 years	10 years	-
WI: 3 years	1 year	5 years	1 year
WY: 2-2.5 years	2 years	-	-

Explanatory Notes for Table A-4

Column 1: Statutory time limit for bringing a suit is measured from the time the injury occurs or from the date of termination of the medical treatment that led to the claim.

Column 2: The statutory time limit for bringing suit is measured from the time at which the plaintiff could have reasonably discovered the injury. Often States allow the time limit to run from either the time of injury or the time of discovery, depending on the nature of the injury.

Column 3: The maximum period in which a claim can be brought, regardless of whether the limit is measured from the date of injury or act or the date of discovery. In most States, this maximum does not apply to the foreign body exception (see column 4).

Column 4: Because of the difficulty of discovering a foreign body (e.g., a surgical sponge) left inside a patient during invasive procedures, a number of States make special exceptions to the statute of limitations for these cases.

[a]This table does not cover special provisions for minors, disabled plaintiffs or cases involving fraud or concealment on the part of the healthcare provider.

O = Provision overturned.

* See additional notes on following page.

** Within year of discovery, maximum number of years do not apply unless stated

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-4

Selected Additional Information:

Alaska--General statute of limitations is two years from date the "cause of action" accrues (Alaska Stat. Sec. 09.10.070 (1962)). Cause of action does not accrue until person discovers or reasonably should have discovered injury. (Dalkovski v. Glad, 774 P.2d 202 (Alaska 1989); Cameron v. State, 822 P.2d 1362 (Alaska 1991)).

Georgia--The statute of limitations in a medical malpractice action may be tolled (i.e., does not accrue) in cases where the parties agree to submit the case to arbitration (O.C.G.A. Sec. 9-9-63).

Louisiana--Time limitation is suspended upon filing a request for review by a medical review panel until 90 days following issuance of the panels opinion (LA-R.S. 40:1299.391A (2)(a); LA-R.S. 40:1299.47A (2)(a)).

Michigan--Special exceptions made in cases involving undiscovered injuries to reproductive system or the presence of a foreign body wrongfully left inside the patient, and in cases where the discovery of basis for claim was prevented by the fraudulent conduct of the health care provider (M.C.L. Sec. 600.5838a(2)(a-c) and (3) (1990)). Claims may be brought two years from injury if discoverable or six months from discovery, whichever is later (M.C.L. Sec. 600.5805(4) (1990)).

Minnesota--Statute of limitations is 2 years from termination of treatment (Minn. Stat. Sec. 541.07 (1992)). Discovery rule has been rejected (Francis v. Hansing 449 N.W. 2d 479 (Minn. Ct. App. 1989); Willette v Mayo Foundation, 458 N.W. 2d 120 (Minn. Ct. App. 1990)).

New Jersey--Years within date of injury apply after accrual of claim (N.J. Rev. Stat. Sec. 2A: 14-2 (1986)). Claim accrues upon reasonable discovery of injury.

New Mexico--The statute is tolled upon submission to pretrial screening panel and shall not run until 30 days after panel makes final decision (N.M. Stat. Ann. Sec. 41-5-22 (Michie 1989)).

Ohio--Suit must be brought within one year from the date of a "cognizable event" or termination of the physician-patient relationship, whichever occurs later (Flowers v. Walker, 589 N.E.2d 1284 (Ohio 1992); Frysinger v Leech, 512 N.E.2d 337 (Ohio 1987)).

Oklahoma--Oklahoma's statute includes a limitation on damages brought 3 years after the injury, but limitation declared unconstitutional. Wofford v. Davis, 764 P.2d 161 (Okla. 1988); Reynolds v. Porter, 760 P.2d 816 (Okla. 1988).

Texas--Statute has been held unconstitutional by the Texas Supreme Court when the injury was not discoverable (See e.g. Neagle v. Krusen, 678 S.W.2d 918 (Tex. 1984); Neagle v. Krusen, 678 S.W.2d 11 (Tex. 1985); Deluna v. Rizkallah, 754 S.W.2d 366 (App. 1st Dist. 1988); but see Rascoe v Anablawi, 730 S.W.2d 460 (App. 9th Dist. 1987)). The courts have essentially modified the statute into a discovery standard.

SOURCE: Office of Technology Assessment, 1993.

Table A-5—Pretrial Screening Panels, by State, 1993

Pretrial screening panels[a]			
Mandatory	Voluntary	No provision	
AK*	AR	AL	ND[R]
HI*	CT	AZ[R]	NJ[R]
ID*	DE*	CA	NY[R]*
IN	KS*	CO*	OH
LA*	NH*	DC	OK
MA*	VA	FL[O]	OR
MD*		GA	PA[O]*
ME		IA	RI[O]
MI		IL[O]*	SC
MT		KY	SD
NE*		MN	TX
NM*		MO[O]	WA
NV		MS	WI[R]*
TN		NC*	WV
UT			WY[O]
VT*			

[a]"Mandatory" includes provisions that allow a waiver of the pretrial screening process upon the request of one or both parties. "Voluntary" refers to provisions that allow but do not require parties to submit their claim to pretrial screening panels.

[R] = Provision repealed
[O] = Provision overturned

* See additional notes on following pages.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES TO TABLE A-5

Cases Overturning Pretrial Screening Panels:

Florida--Aldana v. Holub, 381 So.2d 231 (Fla. 1980).

Illinois--Bernier v. Burrio, 497 N.E.2d 763 (Ill. 1986).

Missouri--State ex rel. Cardinal Glennon Memorial Hospital v. Gaertner, 583 S.W.2d 107 (Mo. Banc. 1979).

Pennsylvania--Mandatory nonbinding arbitration panel provision struck down by Pennsylvania Supreme Court in Mattos v. Thompson, 421 A.2d 190 (Pa. 1980) and Heller v. Frankston, 475 A.2d 1291 (Pa. 1984).

Rhode Island--Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983).

Wyoming--Hoem v. State, 756 P.2d 780 (Wyo. 1988).

Selected Additional Information:

Alaska--Mandatory unless the parties agree to arbitrate or the court determines an advisory panel is not necessary (Alaska Stats. Sec. 09.55.536 (Lexis 1992)).

Colorado--Court may refer cases for mediation at its discretion (Colo. Rev. Stat. Sec. 13-22-301 *et. seq.* (1992)). In addition, the State requires in every action against a licensed professional that the plaintiff file a "Certificate of Review" declaring that the plaintiff has consulted a person with expertise in the area of the alleged conduct and the expert has concluded that the filing of the claim does not lack substantial justification (Colo. Rev. Stat. Sec. 13-20-602 (1987)).

Delaware--Any party can demand that a claim be submitted to a "malpractice screening panel." Results are admissible as prima facie evidence at any subsequent trial. Expert witness testimony may be required for panel (Del. Code Ann. tit. 18, Secs. 6801-6814 (1976)).

Hawaii--Mandatory submission of claim to "medical conciliation panel" but decisions, conclusions, findings, or recommendations of panel are not admissible at trial (Hawaii Rev. Stat. Secs. 671-11 *et. seq.* (Lexis 1992)).

Idaho--Proceedings of informal pretrial screening are confidential and not admissible at any subsequent trial (Idaho Code Secs. 6-1001-1011 (1976)).

Illinois--The State requires medical malpractice plaintiffs to file an affidavit and report of a reviewing health care professional supporting his or her determination that a meritorious cause of action exists. This may be referred to as a "certificate of review" (735 ILCS 5/2-622 (West 1992).

Kansas--Decision of panel is admissible at subsequent trial (Kan. Stat. Ann. Secs. 60-3501-3509 (1987)).

Louisiana--Pretrial screening mandatory unless both parties agree to waive it (La-R.S. Sec. 40:1299.47B(C).

Maine--Mandatory pretrial screening, except if parties agree to waive. Decision is admissible in subsequent trial only if unanimous and unfavorable to claimant as to negligence or causation (24 Me. Rev. Stat. Ann. Sec. 2857 (1990)).

Maryland--All medical injury claims must be submitted to a "health claims arbitration panel" for review prior to trial, unless all parties agree in writing to waive the requirement (which rarely occurs). Although this is called an arbitration panel, it operates more like a pretrial screening panel, with very formal rules of discovery and procedure. The Panel's decision on fault and is admissible at subsequent trial and is "presumed to be correct" (Md. Cts. & Jud. Proc. Code Ann. Sec. 3-2A-03 to -06 (Michie 1989)). The statute was un-

ADDITIONAL NOTES TO TABLE A-5 (Continued)

successfully challenged by plaintiffs on constitutional grounds, Attorney General v. Johnson, 385 A.2d 57 (Md. 1978) *appeal dismissed* 439 U.S. 805 (1978).

Massachusetts–If the panel finds for the defendant and the plaintiff goes to court, they must first file a bond of at least $6000 that will be payable to the defendant if plaintiff ultimately loses bond covers court costs and fines. For indigent plaintiffs, the amount of the bond may be reduced, not eliminated (Mass. Ann. Laws ch. 231, Sec. 60B (Lexis 1992)).

Nebraska–Parties can agree to waive the panel (Neb. Rev. Stat. Sec. 44-2840(4) (1988)).

New Hampshire–Decision of panel not admissible at subsequent trial (N.H. Rev. Stat. Ann. Sec. 519-A:1 to -A:10 (1972)).

New Mexico--Decision of panel not admissible at subsequent trial (N.M. Stat. Ann. Sec. 41-5-20 (Michie 1989)).

New York–A precalender conference in each malpractice case is mandated by law in order to promote settlement, simplify issues and set a timetable for discovery and further judicial proceedings. There is no formal hearing on the merits of the case (N.Y. CPLR Sec. 3406 (McKinney 1985)).

North Carolina–Pilot program (ends in 1995) in which parties to Superior Court civil litigation may be required at the court's discretion to attend a pretrial settlement conference conducted by a mediator (N.C. Gen. Stat. Sec. 7A-38 (1991)).

Pennsylvania–Panels providing "mandatory nonbinding arbitration" were ruled unconstitutional (see above). However, these panels continued to exist and hold "voluntary nonbinding" settlement conferences. In addition, some jurisdictions have standing judicial orders for pretrial settlement conferences for all medical malpractice cases.

Vermont--[Implementation of the following provisions (part of a law passed in 1991) is contingent on future passage of a universal health care coverage plan.] Requires all medical malpractice claims be submitted to nonbinding arbitration prior to a trial. Parties may agree in advance that the arbitrator's decision will be limited to matters of law. If parties do not agree to make the arbitration decision binding, they can proceed to trial. Arbitration decision is admissible at trial but is not definitive (12 V.S.A. Secs. 701 et seq. (1991)).

Washington--Mandatory mediation of all medical malpractice claims prior to trial. Results not admissible at subsequent trial unless both parties agree (State of Washington, Engrossed Second Substitute Senate Bill 5304, 53rd Legislature, 1993 Regular Session).

Wisconsin--Repealed voluntary pretrial screening provision and replaced with mandatory mediation for all medical injury claims ((Wis. Stat. Secs. 655.01-.03 (1977--repealed in 1986; Wis. Stat. Secs. 655.42 et seq. (1985--amended 1989)).

SOURCE: Office of Technology Assessment, 1993.

Table A-6—Attorney Fee Limits,[a] by State, 1993

Sliding scale	Maximum %	Court-determined/ court approved	No statutory limits
CA: 40% of first $50,000	IN-15%*	AZ	AK
33.33% of next $50,000	MI-33.33%	HI	AL
25% of next $50,000	OK-50%	IA	AR
15% damages that exceed $600,000	TN-33.33%	KS	CO
	UT-33.33%	MD*	DC
CT: 33.33% of first $300,000		NE	FL[R]
25% of next $300,000		NH[O]*	GA
20% of next $300,000		WA	ID
15% of next $300,000			KY
10% damages that exceed $1.2 million			LA
			MN
DE: 35% of first $100,000			MO
25% of next $100,000			MS
10% of damages that exceed $200,000			MT
			NC
IL: *33.33% of first $150,000			ND
25% of next $850,000			NM
20% of damages exceeding $1 million			NV
			OH
MA: 40% of first $150,000			OR[R]
33.33% of next $150,000			PA[O]
30% of next $200,000			RI
25% of damages that exceed $500,000*			SC
			SD
ME: 33.33% of first $100,000			TX
25% of next $100,000			VA
20% of damages that exceed $200,000			VT
			WV
NJ: 33.33% of first $250,000			WY
25% of next $250,000			
20% of next $500,000			
Amount shall not exceed 25% for a minor or an incompetent plaintiff			
NY: 30% of first $250,000			
25% of next $250,000			
20% of next $500,000			
15% of next $250,000			
10% of damages exceeding $1.25 million			

Table A-6—Attorney Fee Limits,[a] by State, 1993 (Continued)

Sliding scale	Maximum %	Court-determined/ court approved	No statutory limits
WI: 33.33% of first $1 million OR 25% of first $1 million recovered if liability is stipulated within 180 days, and not later than 60 days before the first day of trial and 20% of any amount exceeding $1 million			

[a]NOTE: Most attorney fee limits are not direct limits on the amount attorneys can charge their clients. Rather, they are limits on the portion of the damage award that may go toward attorney fees.

O = Provision overturned.
R = Provision repealed.

* See additional notes on following page.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-6

Cases Overturning Limits on Attorney Fees:

Pennsylvania--Mattos v. Thompson (421 A.2d 190 (Pa. 1980)) and Heller v. Frankston (475. A.2d 1291 (Pa. 1984)) declared the Health Care Services Malpractice Act unconstitutional because of its mandatory arbitration provision. These rulings also nullified the attorney fee limitations of the Act.

New Hampshire--Carson v. Maurer (424 A.2d 825 (N.H. 1980)) overturned an earlier provision. Another provision has since been implemented.

Selected Additional Information:

Illinois--Where attorney performs extraordinary services involving more than usual participation of time and effort, the attorney may apply to the court for additional compensation (735 ILCS Sec. 5/2-1114 (1992)).

Indiana--For compensation paid from State Patient Compensation Fund, attorney fees may not exceed 15 percent of payments (Burns Ind. Code Sec. 16-9.5-5-1. (Lexis 1992)). However, there are no limits on attorney fees for funds not paid out of the Patient Compensation Fund.

Massachusetts--Court will reduce attorney fees further if they cause plaintiff's final compensation to be less than unpaid past and future medical expenses (Mass. Gen. Laws Ann. ch. 231 Sec. 601 (1986)).

Maryland--Only when legal fees are in dispute must the court or pretrial screening panel approve fees before lawyer collects (Md. Cts. Jud. Proc. Code Ann. Sec. 3-2A-07 (Michie 1989)).

New Hampshire--Court determined attorney fee limits apply only if fees are greater than $200,000 (N.H. Rev. Stat. Ann. Sec. 508:4-e (1986)).

SOURCE: Office of Technology Assessment, 1993.

Table A-7—Arbitration Provisions[a] by State, 1993

Specific provision for medical malpractice claims	General arbitration provision[b]	
AK	AL	NC
CA	AR	ND[R]
CO*	AZ	NE*
FL*	CT	NH
GA	DC	NM
HI*	DE	NV
IL	IA	OK
LA*	ID	OR
MI	IN	PA
NJ*	KS	RI
NY*	KY	SC*
OH*	MA	TN
SD	MD	TX*
UT*	ME	VT
VA	MN	WA
	MO	WI*
	MS	WV
	MT	WY

[a]NOTE: Voluntary, binding arbitration provisions only, unless otherwise noted. This table does not indicate statutory provisions for court-annexed, nonbinding arbitration. Several States have provisions authorizing mandatory, nonbinding arbitration for civil suits where expected damages are below a certain threshold (most thresholds range from $10,000 to $50,000). However, because the vast majority of medical malpractice cases involve expected awards in excess of these thresholds, the provisions are rarely relevant to medical malpractice. One exception is the State of Hawaii, which requires court-ordered nonbinding arbitration for all civil tort actions having a probably jury award (exclusive of costs and interest) of $150,000 or less (Hawaii Rev. Stats. Sec. 601-20 (Lexis 1992)). However, medical malpractice claimants may elect to bypass court-ordered arbitration if a decision has been rendered under the State's mandatory medical malpractice pretrial screening provision (Hawaii Rev. Stats. Sec. 671-16.5 (Lexis 1992)).

[b]Many States have adopted the Uniform Arbitration Act (UAA) (Uniform Arbitration Act, Uniform Laws Annotated (Vol. 7) (St. Paul, MN: West Publishing Company, 1992)).

R = Provision repealed
O = Provision overturned

* See additional notes on following pages.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-7

Selected Additional Information:

Colorado--A medical malpractice insurer can not require a physician to utilize arbitration agreements with patients as a condition of malpractice insurance (Colo. Rev. Stat. Sec. 13-64-403 (1992)). Mandatory arbitration pilot program for all claims ended July 1, 1990 (Colo. Rev. Stat. Sec. 13-22-402).

Florida--In any arbitration, noneconomic damages limited to $250,000 and economic damages limited to past and future medical expenses and 80 percent of wage loss and loss of earning capacity. Defendant will pay claimant's reasonable attorney fees up to 15 percent of award, reduced to present value. Defendant will also pay all costs of arbitration proceedings and fees of arbitration. If defendant refuses to arbitrate, the claim will proceed to trial and there will be no limit on damages. In addition, if plaintiff wins at trial, she will be awarded prejudgment interest and attorney fees, up to 25 percent of award. If claimant rejects arbitration, non-economic damages at trial limited to $350,000. Economic damages limited to 80 percent of wage losses and medical expenses (Fla. Stat. Secs. 766.207, 766.209 (1993 Supp.)). This provision was recently challenged. The trial court found the provision unconstitutional, as did the District Court of Appeals. However, the Supreme Court of Florida recently held the limitation on damages imposed if the plaintiff does not accept arbitration is not unconstitutional. University of Miami v. Echarte, 585 So. 2d. 293 (Fla. App. 3 Dist. 1991) *reversed and remanded* University of Miami v. Echarte, 618 So.2d 189 (Fla. 1993).

Hawaii--Mandatory nonbinding arbitration for all civil actions in tort having probable jury award value exclusive of costs and interest of $150,000 or less (Hawaii Rev. Stat. Sec. 601-20 (1986)). Medical malpractice claims may bypass court ordered arbitration after the claim has been submitted to a medical claim conciliation panel that has rendered a decision (Hawaii Rev. Stat. Sec. 671.16.5 (Lexis 1992)).

Louisiana--No arbitration for claims against State (public) health care providers (LA-R.S. Sec. 40:1299.39.1A(1)). No arbitration for claims against health care providers who are not "qualified" under the PCF requirements (LA-R.S. 40:1299.41(D)).

Nebraska--Pre-injury arbitration agreements are not presumed to be valid, enforceable and irrevocable (R.R.S. Neb. Sec. 25-2602 (Lexis 1992)).

New Jersey--Voluntary arbitration of medical injury claims upon written agreement if greater than $20,000. Applies to all personal injury torts except certain automobile claims (NJ Stat. Sec. 2A:23A-20 (1991)).

New York--Allows defendant to concede liability if the plaintiff agrees to arbitrate. If plaintiff refuses, defendant's concession of liability cannot be used for any other purpose (N.Y. CPLR Sect 3045 (McKinney 1991)). HMOs can put arbitration clauses in contract, but cannot require arbitration as a condition of joining HMO (N.Y. Public Health § 4406-2 (McKinney 1991)).

Ohio--The Ohio statute permits parties to submit a claim to nonbinding arbitration or to enter an agreement to submit the claim to binding arbitration. Such agreements may be made pre-injury. (Ohio Rev. Code Secs. 2711.21-271.24 (1992)). The former provision which requiring submission to arbitration prior to trial and allowed the arbitration decision to be entered into subsequent judicial

ADDITIONAL NOTES FOR TABLE A-7 (Continued)

proceedings was declared unconstitutional by a lower court. Simon v. St. Elizabeth Medical Center 355 N.E.2d 903 (Ohio Ct. Common Pleas 1976).

South Carolina–Statutory provision that sets forth conditions under which arbitration agreements for existing and future controversies will be considered valid, enforceable and irrevocable, does not apply to arbitration agreements for personal injury claims (S.C. Code Ann. Sec. 15-48-10 (1991)).

Texas–Uniform Arbitration Act procedures only apply to personal injury if upon advice of counsel to both parties and both attorneys sign written opinions to this effect (Vernons Ann. Tex. Civ. St. art. 224 (1992)).

Utah–Upon written agreement by all parties, the mandatory prelitigation hearing panel proceeding may be considered a binding arbitration hearing and proceed under the provisions of the general arbitration statute (Utah Code Ann. Sec. 78-14-16 (1985).

Wisconsin–Mediation required prior to initiating or continuing court action (Wis. Stat. Sec. 655.465 et. seq. (1989-1990)). Therefore, general arbitration provision unlikely to be used.

SOURCE: Office of Technology Assessment, 1993.

PREPARED STATEMENT OF RICHARD F. CORLIN, MD

Mr. Chairman and Members of the Committee:

My name is Richard F. Corlin, MD. I am a gastroenterologist in Santa Monica, California and Vice Speaker of the American Medical Association (AMA) House of Delegates. Accompanying me are AMA General Counsel, Kirk B. Johnson, JD, and Hilary Lewis, JD, of the AMA's Division of Federal Legislation.

The AMA appreciates the opportunity to address this Committee regarding the current antitrust environment and its impact on the health care delivery system, both in its present form, and as it will evolve in the future. We believe that the focus on health system reform in the 103rd Congress provides a singular opportunity to take action on a number of viable approaches for improving access to quality medical care. As various options are explored, a reexamination of federal antitrust law and enforcement policy as applied in the health care setting must occupy a preeminent role in the debate. In order to guarantee universal access to cost-effective health care, to assure the delivery of quality medical care, and to preserve the sanctity of the physician/patient relationship, it is imperative that the health care arena function as a meaningful competitive market.

Antitrust reform is needed now because of a rapidly changing health care marketplace. The proliferation of corporate entities owned and operated by insurance companies, hospital holding companies, and other for-profit corporations, will affect the practice of medicine to the detriment of individual patients and health care professionals alike. These corporate entities are typically managed by non-physicians and are focused on the bottom line. Under health system reform, this trend will accelerate.

However, this scenario can be prevented. Appropriate modification of the antitrust laws will enable physicians to reassert their traditional role as patient advocates, even in a health care arena dominated by managed care organizations. The market power of these organizations must be balanced by encouraging the formation of physician-directed health care networks. Physicians, with their knowledge and skill in clinical decisionmaking, can provide the expertise necessary to enable managed care entities to deliver quality medical care in the most cost-effective manner. Therefore, they must be accorded the ability to exercise their professional judgment to ensure that the highest level of care is rendered to patients enrolled in these organizations.

Physicians must be legally permitted to function in this decisive capacity, free from the current impediments that exist under antitrust law and enforcement policy of the Department of Justice (DOJ) and the Federal Trade Commission (FTC). Recognizing this problem, the DOJ and the FTC issued *Statements of Antitrust Enforcement Policy in the Health Care Area* in September 1993. These statements, however, do not address the current complexities in that the safety zones created require a high degree of integration before a physician network can meet antitrust requirements.

A number of legislative proposals, on the other hand, including some that are incorporated in health system reform bills authored by Senators on this Committee, would provide the antitrust clarification that physicians and their patients need. Passage of such legislation would clearly increase the number and quality of competitors in the health care marketplace, with obvious resulting benefits for patients.

THE AMA VIEW

As the following analysis indicates, the proposals for antitrust reform embodied in S. 1770, the "Health Equity and Access Reform Today Act of 1993, "introduced by Senator John Chafee (R-RI), S. 1743, the "Consumer Choice Health Security Act of 1993," sponsored by Senator Don Nickles (R-OK), and S. 1658, the "Health Care Antitrust Improvements Act of 1993," introduced by Senator Orrin Hatch (R-UT) and Senator Strom Thurmond (R-SC), would create appropriate roles for all of the major groups in the health care industry and permit physicians to remain strong patient advocates through active participation in alternative models for health care delivery.

The medical profession is seeking clarification and modification of the antitrust laws, not an exemption. We have always maintained that price-fixing, boycotts, and other coercive practices should be subject to civil and criminal enforcement action by the regulatory agencies. It must be recognized that physician-sponsored networks can offer patients lower costs and higher value. Unlike insurance entities which divert a high proportion of premium dollars to administrative costs and corporate profits, physician-directed organizations are designed to focus assiduously on patient care services.

The antitrust relief that we seek would not permit physicians to restrict the services of other categories of providers. Anticompetitive behavior still would be subject

to civil and criminal penalties. In fact, nearly every major health system reform bill contains provisions to assure access to a wide range of practitioners and to prohibit such discriminatory practices.

It has also been asserted that limited antitrust relief could reduce incentives to improve the quality of care. Under current law, antitrust litigation is traditionally instituted in an effort to circumvent quality of care sanctions resulting from peer review investigations. However, one of the proposed safe harbors outlined in the legislative proposals discussed herein would protect standard setting and enforcement activities by hospital peer review committees and medical societies that promote health care quality.

Finally, antitrust clarification and exemption for the safe harbor activities outlined in S. 1770, S. 1743 and S. 1658 would stimulate incentives for competitive innovation. The Mayo Clinic, the Cleveland Clinic, and the Marshfield Clinic stand as the hallmarks for integrated multi-specialty medical groups that have been sponsored, organized, and run by physicians. These models represent examples of the most successful entities in providing quality medical care to vast numbers of patients at cost-effective prices. Physicians helped to create the nation's largest nonprofit health insurance network and have been the greatest source of innovation in the delivery of health care services. It is certain that antitrust relief in this area clearly would benefit the public by increasing competition, by allowing the professionals most knowledgeable about patient care to direct health care networks and health plans, and by facilitating the formation of health plans that focus on patient interests.

ANTITRUST BARRIERS FACED BY INDEPENDENT PHYSICIANS

As independent physicians contemplate forming multi-specialty group practices, integrated delivery systems, and other health plans, they confront formidable barriers, both economic and legal. The federal antitrust laws stand as the greatest impediment to physicians in traversing this path.

First, independent physicians are foreclosed from organizing even simple health care delivery networks due to the per se illegality rules imposed by antitrust statutes. For example, if MSO physicians belonging to a managed services organization (MSO) agree on the fees and discounts to be offered as a PPO, they will be deemed to be engaged in per se illegal price-fixing. Notwithstanding a minimal hold on the relevant market, and complete inability to ever possess market power, such a conclusion would be reached. Since physicians generally do not have the accounting sophistication necessary to organize capitation and fee withhold arrangements, nor the necessary funds to make capitation successful, they cannot offer a PPO product that would be characterized as legal under current antitrust doctrine. As a consequence, independent physicians must build simpler and cheaper network structures that will provide the experience needed to later create more sophisticated networks. Yet the current antitrust rules virtually preclude their ability to act in this regard.

Once physicians can develop more sophisticated networks, such as PPOs that offer fee withholding arrangements, other antitrust obstacles are encountered. In order to be competitive, a wide choice of physicians, including physicians in various specialties, must be made available by a PPO. Generally, PPOs can maintain a competitive position by garnering 40 percent of the physicians in a market. A physician-sponsored PPO of this size, however, will face antitrust thresholds that are not confronted by insurance companies and other entities. On the other hand, an insurance company may organize a PPO containing 70 percent or more of the physicians in a relevant market without generating antitrust compliance problems, provided other organizations are not foreclosed from access to physicians.

Even more imposing are the antitrust hurdles facing independent providers in rural areas. The demographics in many parts of the country will not foster competition among large HMOs. Alternative forms of provider organizations would represent a viable option, but for the antitrust limits on the percentage of physicians in a market that can be involved in a physician-sponsored network. These constraints thwart the ability of independent physicians to form more efficient delivery networks in small cities and rural areas. Insurance companies, however, are not impeded by antitrust regulatory obstacles in forging similar enterprises.

LEGISLATIVE APPROACHES

The *Statements of Antitrust Enforcement Policy in the Health Care Area* issued by the Department of Justice and the Federal Trade Commission on September 15, 1993 represented an attempt to provide guidance to the health care industry on permissible activities under the federal antitrust laws that would steer and accelerate

the operation of a competitive market. Unfortunately, these statements fail to advance the formation of physician-directed health care delivery networks and health plans to effect wider patient choice. The AMA continues to discuss these matters with the DOJ and the FTC, and we look forward to resolving some of the remaining contentious issues.

While the agencies have indicated their commitment to ongoing review and supplementation of these statements, a legislative solution to the complex questions raised in this area remains imperative. The issuance of advisory opinions relating to physician joint ventures will offer some relief, yet many potentially beneficial enterprises will-never be launched due to the specter of federal investigation and prosecution, prohibitive attorney fees, and treble damages imposed for failure to comply with the antitrust laws.

In our view, these problems can be addressed most effectively through the rational approaches offered in S. 1658, the "Health Care Antitrust Improvements Act of 1993," sponsored by Senator Orrin Hatch (R-UT) and Senator Strom Thurmond (R-SC), as well as S. 1770, the "Health Equity and Access Reform Today Act of 1993," introduced by Senator John Chafee (R-RI), and S. 1743, the "Consumer Choice Health Security Act of 1993," sponsored by Senator Don Nickles (R-OK). S. 1579, the "Managed Competition Act of 1993," proposed by Senator John Breaux (D-LA) and Senator Dave Durenberger (R-MN), also offers relief in directing the President to provide for the development and publication of explicit guidelines on the application of federal antitrust laws to accountable health plans.

The President's proposal, S. 1757, the "Health Security Act," introduced by Senator George Mitchell (D-MN), clearly recognizes the need for antitrust reform. In addition to granting fee-for-service physician networks to negotiate with health alliances, as does S. 1757, health system reform legislation should permit collective negotiations with health plans.

S. 1770 (Chafee), S. 1743 (Nickles), and S. 1658 (Hatch-Thurmond) would allow physicians to assume the critical competitive role appropriate in a health care system dominated by large corporate managed care entities. (For discussion purposes, this statement will address S. 1658, although we recognize that S. 1770 and S. 1743 would provide similar relief.) S. 1658, the "Health Care Antitrust Improvements Act of 1993," presents an interpretation of the antitrust laws that will facilitate the formation of health delivery networks and health plans organized by physicians. The AMA believes that curtailment of the antitrust restrictions that presently have handicapped physician efforts will yield procompetitive results in allowing new entrants—physician-directed entities—into the market for health care delivery and finance. Physicians, who are uniquely qualified to provide health care more efficiently, whose skill and proficiency in clinical decisionmaking sets them apart from other corporate entities, and who are pledged to place patient needs foremost, must be permitted to compete in this arena.

1. Goals of Antitrust Reform

An analysis of health industry groups that will effectively participate in the developing structures indicates that most health care delivery networks and health plans of the future will be operated by insurance companies or hospitals, typically managed by non-physicians. Because these organizations likely will wield control in any given market, non-physicians will be exercising their authority in medical decisionmaking. This disturbing trend can be alleviated through the enactment of the "Antitrust Improvements Act of 1993," which will stimulate the development of a larger number of networks directed by physicians or other providers.

2. Development of Additional Competitive Models

S. 1658 recognizes that physician-directed networks and health plans can provide substantial benefits, particularly in a marketplace where the provision of insurance and health care services are being fused into a single product—the prepaid health plan. In an increasingly complex environment of health care delivery networks and insurance companies with intersecting goals, the simple physician network can further competition by vying for contracts to deliver health care. Any network that unites price reduction with quality, in an effort to compete with insurers for health care delivery services purchased by self-insured employers, should be permitted to flourish.

The origin of physician-directed integrated delivery systems can be traced to the successful competitive benefits realized by the simpler network models. Integrated delivery systems can achieve these competitive goals on a larger and more comprehensive scale by competing for contracts with insurers, competing with insurers for the business of self-insured employers, and competing also for the actual business of insurance. They do not require substantial administrative overhead and can,

therefore, offer a competitive product at a lower cost. Successful examples of these systems can be cited in Los Angeles and Boston. In the former market, in which a majority of the population is enrolled in HMOs, the Mullikin Medical Centers represents a physician-directed health plan that has recently offered the lowest premiums.(1) Similarly, a physician-directed HMO in Boston is able to offer care to patients at some of the lowest prices in that market.(2)

Finally, physician-directed plans are more likely to act in a manner more sensitive to individual patient needs. For example, several insurance companies have incorporated the use of "optimal recovery guidelines" in determining appropriate lengths of hospital stay. These guidelines have been based on the top 10 percent of patient outcomes of those with the fastest and easiest recoveries, rather than from the average case.

Another area where business management priorities often prevail over patient interests is the approach to coverage and reimbursement determinations. Denial of coverage decisions have also brought about adverse consequences. The recent HealthNet case offers an egregious example of a patient who was denied reimbursement for a bone marrow transplant recommended by her physicians. The ensuing litigation led to an award of $89 million in damages.

The lessons are clear. When prescriptive guidelines fail to consider individual patient needs and are implemented in a manner that impacts deleteriously upon patient care, negative consequences occur. That is why the AMA urges that physician involvement comprise an essential part of any health plan operation. Clearly, physician-directed health plans would provide the most direct avenue for such participation.

3. Antitrust and the Health Care Industry

It has been argued that the same antitrust standards should apply to health care as to all other industries. The fundamental tenet of antitrust policy—that competition should be preserved and promoted—must remain paramount. However, the A MA takes issue with the view that health care is like other industries, and that the same antitrust principles should apply. The staggering number of legislative proposals to substantially reorganize health care, pending in both Congress and the state legislatures, bears witness to the singularity of this industry in a number of respects. For example, the President's proposal, S. 1757, the "Health Security Act," would comprehensively revolutionize health care finance and delivery, the education of health care professionals, the regulation of quality, and virtually every other aspect of the industry.

The current imperative to guarantee universal access further distinguishes health care from those industries in which consumers are priced out of the market because they are unable or unwilling to purchase a product at the prices offered. As health system reform takes shape, and care will be provided to every citizen who needs it, a different set of imperatives should apply. Therefore, market dynamics to maximize quality, while containing costs, must be harnessed on behalf of a product that will be provided to all who need it.

No other industry faces this daunting challenge. In the legislative context, antitrust exemptions have been afforded to other industries that do not fit the usual mold. The insurance industry, farm cooperatives, labor union activities, public utilities, the securities and commodities industry, and communications companies have benefitted from statutory relief. Antitrust standards have also been modified on behalf of banks and other financial institutions. The insurance industry already reaps the benefits of a significant antitrust exemption that allows it a clear advantage in competing in the health care environment.

While the "Health Care Antitrust Improvements Act" would not create expansive waivers, it would modify the interpretation of the antitrust laws with respect to physician networks and health plans to reduce barriers to their creation. It thus recognizes that health care delivery is now organized under a new set of assumptions: namely, that the concept of the individual physician as a solo entrepreneur has been supplanted by the physician as part of a large organization.

The interpretations offered by S. 1658 would not alter immutable antitrust principles. Obviously, antitrust laws must apply to physician-directed health care delivery networks. However, the focus must be changed to reflect the dynamic nature of the industry. Replacing antitrust laws with FTC/DOJ regulation was questionable even in endeavoring to fill the void created by federal judicial decisions in the 1980s. Development of industry regulations has not been the customary prerogative of the DOJ or the FTC. As the pace of managed care activity has escalated in recent years, the demand for a more coherent regulatory framework with substantial formal public input has increased. Although the aforementioned September 1993 guidelines signify a major step in this direction, many issues remain unanswered. The AMA

believes that the "Health Care Antitrust Improvements Act of 1993" would provide the coherent regulatory structure and necessary formal public input to respond to outstanding issues.

4. Antitrust Remedies

The "Health Care Antitrust Improvements Act of 1993" would redress many of the problems outlined earlier with respect to independent physicians and other independent providers who seek to assume a constructive role in the new competitive strategies that are being formulated. The bill would establish the following four mechanisms: (1) a defined safe harbor for clearly procompetitive physician joint venture networks; (2) a mechanism for the creation of additional safe harbors for physician joint venture networks that prove to be procompetitive; (3) a procedure for certificates of review, whereby safe harbor status could be accorded to procompetitive individual joint venture networks; and (4) a procedure by which procompetitive physician joint venture networks that meet certain size and financial risk-sharing requirements, but do not fall within a safe harbor, could be judged according to a rule of reason analysis and actual damages, rather than being adjudged as per se illegal and subject to treble damages.

The AMA supports these four carefully crafted provisions that would preserve the abiding principles of antitrust laws and also prevent anticompetitive abuse. Any possibility that a set of physicians acting in bad faith could injure competition is minimized.

a. Safe Harbors

S. 1658 contains seven safe harbors that would exempt the covered activities from the antitrust laws. Our testimony will focus on some of the safe harbors that apply to physicians.

The first safe harbor would exempt any activities relating to health care services of any combination of providers, if the total number of each type or specialty of the provider in question does not exceed 20 percent of the total number of that type or specialty in the relevant market area. Independent providers, therefore, could form simple networks without incurring antitrust sanctions. Networks that meet the 20 percent test could be constituted with virtual impunity, provided that all other statutory requirements are met.

This safe harbor bears little potential to result in abusive anticompetitive behavior. A combination of 20 percent of the providers in a market will not command sufficient market power to restrict output and raise prices. In addition, only a limited range of products can be successfully organized under this safe harbor. Because a viable PPO should be comprised of at least 40 percent of the physicians in a market, the networks organized pursuant to this safe harbor would have difficulty in competing for business with larger insurance company-organized PPOs, and could be better presented as steppingstones to more comprehensive health care delivery networks assembled by others.

The Department of Justice has raised concerns that the safe harbors may permit destructive anticompetitive behavior, and that statutory safe harbors will become inflexible and not amenable to change if they prove to be inappropriate. But the scope of this proposed safe harbor is so limited that it will not present any serious threat to competition. While the risk will always persist for isolated individuals to act in bad faith for personal gain and, thereby, abuse a safe harbor, this must be balanced against the potential benefit of fostering the development of simple physician-directed networks. In this light, the possible abuses ebb in importance.

Although the Department of Justice argues against legislation on the grounds that regulatory guidelines are more susceptible to modification than Congressional action, S. 1658 empowers the DOJ to create and dismantle additional safe harbors. DOJ would also be authorized to grant certificates of review to individual networks. These provisions grant the flexibility needed to adjust to changing market conditions.

Section 4 of the Act would direct the DOJ to consider requests from the public for the designation of additional safe harbors. A number of factors would be weighed in determining whether a given proposal would promote or harm the operation of the market. The DOJ would be authorized to extend safe harbor status to specific kinds of networks or cooperative activities that have a demonstrably procompetitive effect on the market. The criteria employed grant additional flexibility to the Department in this area. With the advent of rapid consolidation and the compelling need to achieve cost savings, procompetitive conduct should not be hampered by legal uncertainty with respect to antitrust status.

The designation of additional safe harbors also will confer a benefit upon networks organized in small cities and rural areas. An evaluation of networking activi-

ties that are most conducive to expanded competition should serve as the starting point for any determination that a procompetitive combination comports with antitrust strictures.

Unfounded concerns have been raised regarding the potential for anticompetitive abuses under the sale harbors. Because the authority to designate additional safe harbors resides with the DOJ and would be guided by criteria intended to serve the public interest, the potential for abuse under new safe harbors is slight. This potential can be mitigated further as the DOJ can always modify or eliminate a safe harbor that creates unforeseen consequences.

According to the Department, the process for creating additional safe harbors may result in the over-regulation of health care. Misgivings in this area may indeed be legitimate, but the Act envisions a structure whereby the Department, in conjunction with the FTC and the Department of Health and Human Services, is charged with the regulatory burden. By placing the initiative for the designation of additional safe harbors with providers, a coherent and interactive regulatory process between health care providers and the government would exist to ameliorate any risk of over-regulation. The AMA is confident that the agencies involved would act in good faith to implement their mandate, rather than paralyze the industry with excessive regulation.

Finally, it has been asserted that the bureaucratic process of designating additional safe harbors under S. 1658 may overburden the DOJ given its present resources. While this activity will require expanded work, providers who request a safe harbor would be required to meet the standards set forth in the measure and also persuade the Department that the public interest will be served through the creation of the proposed safe harbor. If additional staff is needed to handle this responsibility, the necessary resources should be provided. Health system reform will bring about the reorganization of one-seventh of our economy. Surely, a small number of new staff amounts to an insignificant price tag to assure that the reorganization proceeds smoothly and properly, with patient interests residing at the forefront.

b. Certificates of Review

Section 5 of the "Health Care Antitrust Improvements Act of 1993" would allow physician networks to apply to the DOJ for a certificate of review. If the certificate is approved, the network would be secure from antitrust risk for legitimate, procompetitive activity. These certificates would be especially useful to networks organized in small cities or rural areas, as each region may present different market conditions. Rather than relying on a broad safe harbor, the certificate of review could authorize particular types of networks tailored to different markets.

Because the DOJ is granted the discretion to approve or disapprove of requests for certificates of review, it is unlikely that their issuance will have an adverse impact upon competition in any market. A certificate obtained through bad faith and abuse can be terminated. Nor does the certificate of review process create a potential for over-regulation. Once again, providers would initiate the requests for certificates. Those who are confident that their networks comply with the antitrust laws will not engage in the superfluous exercise of obtaining a certificate. Finally, this mechanism does not threaten to overburden the DOJ. Fifteen states have procedures that allow hospitals, id other categories of providers, to request "certificates of public advantage" or "certificates of review."(3) In those states where the statutes are operational, the state agencies responsible for reviewing requests for certificates have not been overwhelmed.(4) (Attachment B)

c. Notifications

Section 6 of the "Health Care Antitrust Improvements Act of 1993" would permit provider joint ventures to file a notification with the DOJ after an agreement to form such a venture is executed. The voluntary application process would subject the venture to rule of reason analysis in evaluating its legality under the antitrust laws. The rule of reason examination evaluates the venture's impact upon competition. Joint ventures that have filed notifications would not be deemed illegal per se, but they would have to prove that their activity will not pose any anticompetitive risk. This requirement diminishes the potential for anticompetitive abuse for two reasons. First, the DOJ would have the opportunity to review notifying joint ventures and prosecute those that it considered to be illegal. Second, private parties are also granted the right to institute claims against notifying joint ventures.

Again, if any administrative burdens arise from notification filings, the AMA underscores its earlier recommendation that the DOJ be supplied with the necessary personnel to process these applications.

d. Deemed Notifications

Joint ventures that meet certain size and financial risk-sharing requirements would be deemed to have notified the DOJ without actually filing a notification pursuant to Section 6 of S. 1658. Rule of reason treatment would be extended to ventures that meet the outlined characteristics.

According to the requirements set forth in the measure, the joint venture must consist of a non-exclusive network of non-institutional providers not greater than 50 percent of the providers in the relevant market, in aggregate and by specialty. An exclusive network can be comprised of only 35 percent of the providers in the market in aggregate and by specialty. In addition, each member of the network must assume substantial financial risk for the operation of the venture, including, but not limited to, the acceptance of capitation contracts, the acceptance of contracts with fee withhold arrangements, or the holding by members of significant ownership or equity interests in the venture. The capital contributed by members must also be used to fund the operational costs of the venture, such as administration, marketing, and computer-operated medical information, provided that the venture develops and operates comprehensive programs for utilization management and quality assurance that include controls over the use of institutional, specialized, and ancillary medical services. The AMA concurs with the application of a reasonableness standard to joint venture networks of non-institutional providers. Such networks are so likely to be pro-competitive that actual notification is not necessary. They may still be prosecuted by federal or state law enforcement agencies or by private parties if used for anticompetitive purposes.

A procompetitive network must be competitively viable by offering a wide choice of providers to patients in order to be competitive with insurance company networks that offer a wide choice. Such a network must include a large percentage of physicians in the market. Insurance company PPOs are generally nonexclusive, and they typically consist of more than 50 percent of the physicians in the market on their panels. In addition, the criteria for risk sharing add further assurances that the goals of the joint venture are procompetitive. PPOs that operate on a discounted fee-for-service basis would fall within deemed notification status by demonstrating a sufficient degree of integration to qualify. Members would have to invest money in the venture subject to risk of loss and the opportunity for a return of profit. The investment must also be used for purposes that indeed make the venture procompetitive.

Because the antitrust laws would apply to the joint ventures within the deemed notification category, with these enterprises precluded only from an adjudication of per se illegality, the potential for anticompetitive effect is nominal. The ability to sustain competition is further buttressed by the conservative thresholds of size that would be accorded rule of reason scrutiny. Finally, the DOJ and FTC would be engaged in their customary regulatory efforts, obviating any need for over-regulation.

CONCLUSION

The AMA strongly recommends changes to the current antitrust environment, particularly as health system reform will dictate the use of new competitive approaches for the delivery of affordable medical care. Managed competition will require the incorporation of substantial efficiencies, making cooperation among health care providers and coordinated activity on behalf of patients imperative. Health care antitrust relief will permit physicians to form networks to address the changes that will inevitably occur and provide valuable input into the policymaking activities of managed care plans. Appropriate legislative solutions, such as those now being considered, will contribute to the success of any model for health system reform that is ultimately adopted.

The AMA appreciates the opportunity to appear before this Committee. We will be pleased to respond to questions.

ENDNOTES

1. Jacque J. Sokolov, MD, *Advanced Integrated Health Systems,* Health Care Advisory Board, Washington, DC (1994), page 30.
2. Id. at 39.
3. These 15 states are: Colorado, Colo. Rev. Stat. Ann. §24–32–2701 (1993); Florida, Fla. Stat. Ann. §395.606 (1993); Iowa, Senate File 380, amending Iown Code Ann. §96.3 (1993); Kansas, 1992 Kan. Sess. Laws 158, amending Kan. Stat. Ann. §6525 (1992); Maine, Me. Rev. Stat. Ann. tit. 22, §§1881–1887 (1992); Minnesota, Minn. Stat. §62J.29 (1992); Montana, 1993 Mont. Laws 606; North Carolina, 1993 N.C. Sess. Laws 529; North Dakota, 1993 N.D. SB 2295; Ohio, Ohio Rev. Code Ann. §3727.22 (1994); Oregon, SB 683; Tennessee, 1993 Tenn. Pub. Acts 331; Texas, 1993 Tex. Gen. Laws 638; Washington, Wash. Rev. Code Ann. §39.34,43.72.310,70.44 (1994); and Wisconsin, Wis. Stat. §150.84–150.86 (1992). The Oregon statute is limited to cooperative ventures for kidney and heart transplant services. The Florida and Kansas statutes are limited to rural cooperative health care delivery networks. The statutes in Colorado, Maine, Montan, North Carolina, Ohio, Tennessee, and Texas apply to hospitals or health care facilities only. The remaining statutes—Iowa, Minnesota, North Dakota, Washington, and Wisconsin—apply to cooperative ventures or organized health delivery system cooperatives created by any kind of provider.
4. The AMA has surveyed the fifteen states involved to determine the regulatory burden that has resulted from these statutes. The survey results are attached. (Attachment B)
5. Richard Kronick, PhD, David C. Goodman, MD and John Wennberg, MD, "The Demographic Limitations of Managed Competition, *New England Journal of Medicine,* January 14, 1993.
6. David E. Vogel, *The Physician and Managed Care,* American Medical Association (1993), page 19.
7. Harris Meyer, "Insurance Giants Bet on Managed Care," *AM News,* February 7, 1994, page 3.
8. *Marion Merrell Dow Managed Care Digest: HMO Edition 4(1993),* note 8, page 4.

Attachment A

CONSOLIDATION IN HEALTH CARE MARKETS

Some examples of the growing consolidation of health care in a number of markets are summarized below:

Minneapolis. In Minneapolis, HMO penetration is even higher - 44% of local residents belong to HMOs. In the last year, 2 of the 4 biggest hospitals merged and 2 of the 4 dominant HMOs announced a merger. Employers and consumer advocates are concerned about the rapid consolidation taking place in the market. Barriers to entry are high and large capital reserves are required. In addition, without large numbers of patients, plans cannot attract doctors and hospitals; without doctors and hospitals, plans cannot attract patients. Leaders of the Business Health Care Action Group, more than a dozen Minneapolis-based employers (including Dayton-Hudson; Cargill Inc., General Mills Inc., Honeywell Inc. and Pillsbury Co.) who are otherwise free-market supporters, argue that health care should be viewed as a "kind of a public utility".

Los Angeles Area. The Los Angeles area, including the counties of Los Angeles, San Bernardino, Orange, Venture, and Riverside, has a population of about 14.5 million. The evolution of managed care is very advanced in this area. In fact, Los Angeles, is one of the most advanced managed care markets in the U.S. About 36% of the beneficiaries are enrolled in HMOs, and 35% in PPOs, for a total managed care market share of 71%. There are 32 HMOs and 30 PPOs operating in that market. However, just seven HMOs account for 7,030,000 beneficiaries. The largest HMO has an enrollment of 2,280,000, and the next largest has 1.6 million enrollees.

Albuquerque, New Mexico. The Albuquerque, New Mexico area has a population of about 612,000. The evolution of managed care is also very advanced in this market. Managed care plans have a 75% share of the insured population. Five HMOs cover 262,000 persons, and PPOs cover 88,000 beneficiaries.

Boston Area. The Boston area, including Essex, Middlesex, Norfolk, Suffolk, and Worcester Counties, has about 2.9 million people. Boston is relatively advanced in the evolution of managed care, but not as advanced as Los Angeles and Albuquerque. About 32% of the beneficiaries are enrolled in HMOs, and 21% in PPOs. There are over 12 HMOs and 20 PPOs. The five largest HMOs have 1,275,000 members. The largest HMO has 500,000 enrollees, and the next largest has 380,000.

Washington, D.C. Area. The Washington, DC area, including the District of Columbia, Northern Virginia, and Maryland, has about 3.7 million people. It is in about the same stage of evolution as Boston. About 26% of the population is in HMOs and 37% in PPOs. There are over 14 HMOs and 16 PPOs. The five largest HMOs have 1,030,000 of the beneficiaries. The largest of those HMOs has 450,000 members.

Chicago Area. The Chicago area, including the counties of Cook and DuPage, has about 5.9 million people. The evolution of managed care is not as advanced as in Los Angeles, Albuquerque, Boston, and Washington D.C. In fact, Chicago is at a relatively early stage, but the evolution is proceeding rapidly. About 22% of the beneficiaries are enrolled in HMOs, and 30% in PPOs, for a total managed care enrollment of 52%. There are over 20 HMOs and more than 25 PPOs operating in the market. The five largest health plans, including HMOs and PPOs, account for 850,000 enrollees. The largest HMO has 370,000 -- relatively small considering the size of the market.

Atlanta Area. The Atlanta area, including Fulton, Cobb, Douglas, and Dekalb Counties, has about 1.7 million individuals. Atlanta is also at an early stage in the evolution of managed care. About 18% of the beneficiaries are in HMOs, and 48% in PPOs, for a total of 66%. There are 10 HMOs and 15 PPOs. The five largest HMOs have 460,000 beneficiaries, and the largest has 160,000.

ATTACHMENT B

FIFTEEN STATE SURVEY OF LEGISLATION PROVIDING FOR CERTIFICATES OF PUBLIC ADVANTAGE

STATE	LEGISLATION	ADMINISTRATIVE COSTS	NUMBER OF APPLICATIONS
CO	Colo. Rev. Stat. Ann. § 24-32-2701 (West 1993).	According to Larry Wahl of the Colorado Hospital Association, the provision, which was passed last year, has not been implemented. Consequently, no funds have been allocated to administer the act.	The provision has not been implemented and has generated no applications.
FL	Fla. Stat. Ann. § 395.606 (West 1993).	Information not yet received.	Information not yet received.
IA	Senate File 380, amending Iowa Code Ann. § 96.3 (1993).	Barb Nervig in Iowa's Department of Public Health said that no rules have been promulgated yet. Consequently, no budget allocations have been made.	Because the act is not yet operational, no applications have been filed. However, several vertically integrated health care cooperatives are in the process of forming without immunity from antitrust liability.
KS	1992 Kans. Sess. Laws 158, amending Kans. Stat. Ann. § 65-425 (1992).	Chip Wheelen, the Kansas Medical Society's Director of Public Affairs, said that no budget allocations had been made nor applications filed as of February, 1994.	

ME	Me. Rev. Stat. Ann. Tit. 405-D §§ 1881-88 (West 1992).	According to John Dickens in the Health Planning Division of Maine's Department of Human Services, $100,000 per year has been budgeted to sustain the program. It is administered by two half-time attorneys in the Attorney General's Office, one half-time analyst, and one half-time secretary. The act is self-funding; all hospitals in the state must make a yearly, pro rata contribution to the state to sustain the program.	To date, one certificate of public advantage has been issued. However, it has resulted in a great deal of strategic planning and networking on a regional basis. In addition, the Attorney General has provided legal assistance to hospitals considering availing themselves of the provision. John Dickens attributes the lack of applications to the "wait and see" attitude many hospitals have adopted in response to health care reform.
MN	Minn. Stat. § 62J.29 (1992).	Nan Schroeder, a Division Director for the Minnesota Department of Health, estimated that she or another director will devote about 20% of her time to the project. In addition, the following resources and budget allocations would be required: •One full-time attorney •One half-time research analyst •Two full-time personnel positions ($75,000-90,000) •One economist on contract ($40,000) •Administrative law hearings ($20,000)	Only two hospitals have filed an application to date. David Renner at MMA attributes this to the expense and paperwork involved in the application process. In addition, most cooperative arrangements in Minnesota have been vertical, not horizontal, and have therefore not needed immunity from antitrust liability.

MT	1993 Mont. Laws 606.	Sam Hubbard of the Montana Health Care Authority reported that rules and regulations have not yet been promulgated. He does not know how much of the Health Care Authority's $1.35 million budget will be allocated to this provision. He hopes that his staff of six full-time employees will be able to administer the program.	Because the act has not been implemented, there have been no applications filed. Montana has only four communities with more than one hospital. Several of these hospitals have expressed interest in the program.
NC	N.C. Sess. Laws 529.		Ann Hale of the North Carolina Medical Society said that the effectiveness of the provision has been questioned by some attorneys and the provision has not generated many applications.
ND	1993 N.D.SB 2295	Fred Larson in the State Health Department reported that the hearing on rules and regulations was held during the week of February 14, 1994. As a result, no budget allocations have been made. The rules and regulations should be in final form by May 1, 1994.	The provision has not been implemented and has generated no applications.

OH	Ohio Rev. Code § 3727.22 (1992).	Review of applications, issuance of certificates, and supervision under Ohio's Act are being handled by existing staff in the Health Department's Certificate of Need Division. No funds have been allocated under this provision.	According to Tom Moore in the Health Department, only two applications have been filed since the provision was implemented in April, 1993.
OR	S.B. 683 (Oregon Legislature)	Chad Cherial in Oregon's Office of Health Policy estimated that a biannual budget of $50,000 would be required to draft rules, provide for review by the Attorney General's Office, allow for a public hearing, and process and monitor applications. In addition, .3 FTE's will be needed in the first year and .2 FTE's thereafter. Staff will be drawn from existing personnel.	Because the statute only applies to cooperative ventures in the realm of heart and kidney transplants, only three providers in the Portland area will be affected. No applications have been filed.
TN	1993 Tenn. Pub. Acts 331.	Three positions were created to administer the provision: an attorney, a health planner, and a secretary. In addition, one or two existing attorneys in the Attorney General's Office will be involved. The program is designed to be self-supporting with funds from application fees.	The act is not yet operational. However, according to Paku Khan, the Assistant General Counsel in the Department of Health, several parties have expressed an interest in applying for certification.

TX	1993 Tex. Gen Laws 638.	There has been no demonstration of costs yet for the Texas statute. Consequently, no funds have been allocated to the project. Tyrone Sharpe in the Department of Health anticipated that the $10,000 application fee will fund three new positions (one in the Department of Health, one economist, and one liaison to the Attorney General's Office)	The provision will not be operational until March 1, 1994, so no applications have been received.
WA	Wash. Rev. Code § 39.34 (1993).	Tina Kondo in the Antitrust Section of the Attorney General's Office said that $500,000 has been set aside for the statute's first two years. $350,000 will fund the Health Services Commission, and $150,000 is to go to the Attorney General's Office.	No rules have been promulgated and no applications have been received.
WI	Wis. Stat §§ 150.84 - 150.86	Steven Siegel in the Office of Policy and Budget said that no provisions have been made for staff or funding.	Colleen Wilson at SMSW said that no applications have been received. Although physicians and other providers have expressed interest in the statute, they have been advised that there may not be enough state involvement and supervision to avoid antitrust liability under Ticor.

APPENDIX

ANTITRUST AND MANAGED COMPETITION

The health care industry finds itself in the midst of a revolution, with the dramatic consolidation of health care insurers and health care providers into unified entities that both finance and deliver health care. Physicians, hospitals, and other providers are being organized into comprehensive health care delivery networks that serve as the provider component of these plans.

These business arrangements focus on one primary objective -- the achievement of cost containment: (1) through the application of management techniques that cannot be employed when providers operate independently and without coordination; and (2) through the advantages rendered by economies of scale in assembling the maximum number of beneficiaries that can be managed within this framework. In this atmosphere, health care providers will be expected to work cooperatively so that the resulting structures are capable of rendering efficient, cost-effective, and quality health care. Only if physicians are accorded a meaningful role in this changing environment will we ensure that the commitment to our patients supersedes the financial goals of corporate plans.

1. The Consolidation of the Health Care Industry -- Background

The transformation of the health industry is being driven by compelling market forces and the desire for total reform of the health care system. The consolidation process is viewed as a means to develop enterprises that can reduce costs by organizing health care delivery in ways that are more efficient than conventional medical practice. This consolidation is occurring on a massive scale, with experts identifying the most efficient health plans as group or staff model health maintenance organizations (HMOs) with at least 450,000 enrollees who will maximize the use of a fully comprehensive health care delivery network dedicated to the care of their beneficiaries.[5] While many areas of the country lack sufficient population to support competition between three or more health plans of this size, efficient HMOs of smaller sizes may succeed in competing in these locales. There is a potential, and a growing reality, that a small number of group or staff model HMOs will deliver all of the health care in any given market.

Many health care system analysts have theorized that competing health care delivery networks and health plans will be developed to deliver care in the future. In this construct, the most efficient networks will gain market share at the expense of their rivals. In fact, such consolidation already is taking place. Although HMO enrollment has steadily increased from 1980-1992, the number of HMOs peaked in 1987 with 650, and declined to 546 as of December 1992,[6] as some HMOs have acquired others, and some have gone out of business entirely. In certain markets, more than 50 percent of health plan beneficiaries are enrolled in managed care plans, including HMOs and PPOs. A small number of health plans is accounting for a greater percentage of beneficiaries in those markets. Some of the areas seeing that have witnessed this trend include: Los Angeles, Albuquerque, Boston, Washington, DC, Chicago, and Atlanta. (ATTACHMENT A)

At first, extensive consolidation into such integrated systems appears to generate a spiralling phenomenon with providers tending to participate in many managed care plans upon their inception in a given market. Further evolution of managed care, however, usually results in many providers ultimately serving only a small number of plans. If current predictions are reliable, a reorganization of unprecedented scope is expected as several hundred thousand currently independent providers, including hospitals, other health care facilities, physician practices, and other health care professionals now engaged in independent practice perhaps will be organized into 5,000 to 10,000 health care delivery networks.

2. The Pace of the Consolidation

Although the consolidation process is proceeding rapidly, it will not be completed overnight. Delays in implementation probably can be attributed to lack of patient acceptance. Patients quickly become disenchanted when they discover that managed care plans restrict their freedom to be treated by the provider of their choice.

From an administrative perspective, the provider infrastructure for medical management of a plan's health care delivery network must attain a level of sophistication and knowledge critical to achieving efficiencies that will ultimately reduce plan premiums, yet maintaining quality. Finally, vast amounts of capital are needed to build managed care organizations in order to develop a provider network, administrative and information support systems. Clearly, management expertise and accumulation of capital require a concomitant investment in time, and these goals can overtake patient care needs.

Typically, consolidation in health care markets begins with a proliferation of simple networks and managed care products, such as indemnity plans that employ utilization review, and various kinds of preferred provider organizations (PPOs) offering incentives for beneficiaries to use a restricted panel of providers who have agreed to discount their fees. The surge of larger, more sophisticated managed care plans generally can be traced to the success of earlier, less sophisticated endeavors. In markets where large group or staff model HMOs dominate, this process has been documented.

3. Who Will Direct the Health Plans and Health Care Delivery Networks

Most health care system analysts have predicted that health care in the future will be delivered by "integrated" systems owned by insurance companies or other for-profit businesses, primarily accountable to their shareholders. A number of health care industry groups are positioning themselves to operate health plans or health care delivery networks that serve health plans. These groups include: (1) traditional insurance companies; (2) hospital holding companies, (3) corporate entrepreneurs; (4) large physician group practices; and (5) independent physicians in small group practices or in solo practice.

Success in this effort will require capital, experience in insurance or medical management, ownership or access to a significant component of a health care delivery network or health plan, and access to managerial talent as well. Large insurance companies obviously possess the greatest advantage in coordinating all of these segments. For example, the eight largest insurance companies own 45 percent of the nation's HMOs.[7] Major insurance companies own 42 percent of the PPOs.[8] These companies are in the process of building their health care delivery networks through strategies that contemplate: (1) the acquisition of HMOs and PPOs; (2) joint venture efforts to form HMOs and PPOs with existing integrated health care delivery systems; and (3) the acquisition or establishment of primary care physician practices.

Aetna Health Plans now operate 28 HMOs in 19 states, with a projected investment of one billion dollars in managed care over five years. Aetna also has decided to create its own primary care-oriented physician practices in several cities. Cigna Healthcare, which now has 42 HMOs in 27 states, is considering the purchase or creation of 400 physician practices nationally in a $150 million program over 10 years. Prudential Health Care Systems, operating 28 HMOs in 18 states, is engaged in buying or establishing physician practices in several cities. Finally, Travelers Health Network, with 9 HMOs in 6 states, and Met Life Health Care, holding 14 HMOs in 14 states, have agreed to combine their managed care organizations into a joint venture initiative.

Similarly, hospital holding companies are well-positioned to develop and operate HMOs. Their favorable status is derived from owning the primary element of any health care delivery network -- hospitals. Through their relationship with hospital medical staffs, moreover, they have

access to the other integral factor in any network -- physicians. Investment capital, managerial talent, experienced medical management, and PPO and HMO operations are also available to hospital holding companies. At the present time, hospitals are building their health care delivery networks by organizing physicians on their medical staffs into physician hospital organizations (PHOs), affiliating with large physician group practices, and purchasing or starting primary care physician group practices.

For corporate entrepreneurs, capital and managerial talent are not in short supply, though experience in medical and insurance management may be lacking. Generally, their access to health care delivery networks is minimal. As a consequence, they usually acquire and manage physician practices.

Large multi-specialty group practices of physicians also enjoy advantages in owning a physician network, and either owning or being affiliated closely with a hospital. Thus, they can offer an integrated health care delivery network. Many even own and operate health plans. These large group practices also have access to managerial talent, substantial capital, and medical management experience. Some examples of large successful group practices include the Mayo Clinic and the Cleveland Clinic.

In this configuration, physicians in solo or small group practice constitute the most poorly positioned of the health industry sectors in creating health care delivery networks. Although they certainly have the potential to create networks that feature high quality of care and patient service, while minimizing annual per patient costs, they do not possess the requisite capital or managerial talent. Those physicians that are considered desirable for network participation, especially primary care physicians, are more likely to be solicited by hospitals and insurance companies to sell their practices or formally affiliate.

Independent physicians that do not want to accept such offers must, therefore, design new health care delivery systems in concert with others who are similarly situated. Management services organizations (MSOs) represent one vehicle by which these individuals may remain financially independent yet work with others. MSOs do not require a high capital investment or complex managerial experience. They do provide shared management services, such as billing, collections, scheduling, and purchasing to reduce the overhead costs to each physician. MSOs also perform medical management functions, such as utilization review, quality assurance, and coordination of referrals.

The network may be offered to self-insured employers or insurers as a PPO, or to those seeking to assemble a comprehensive health care delivery system. Successful MSOs can evolve into new multi-specialty groups of physicians through coordination of their practices and investments in other shared facilities, such as new clinics or outpatient surgery centers. That kind of success enables MSOs to attract capital and expand their functions. With more sophisticated management, they can affiliate with or acquire hospitals and, therefore, become more integrated delivery systems. The addition of insurance capabilities will eventually permit integrated delivery system to flourish into health plans.

PREPARED STATEMENT OF JACQUELINE A. CORRIGAN

Thank you, Mr. Chairman. We are presenting this testimony to provide the Committee with information on medical malpractice reforms and their impact on malpractice costs. Our comments today are drawn from a background paper done as part of OTA's study on defensive medicine and the use of medical technologies. The study was requested by Congressman Bill Archer, Ranking Republican member of the House Ways and Means Committee and Senator Orrin Hatch, a member of OTA's Technology Assessment Board. Our requesters asked OTA to examine the costs and causes of defensive medicine, which OTA defines as physicians' decisions to use medical technologies primarily out of concern for potential malpractice liability. This study is now nearing completion and will be published in the early summer.

As part of the assessment, and to assist our Congressional requesters in the debate about medical malpractice reform and health care costs, we undertook a background paper to examine the impact of tort reforms on the direct costs of compensating victims of medical negligence. The primary purpose of the paper was to examine the evidence on the impact of malpractice reforms on reducing direct malpractice costs. Direct malpractice costs are defined as the cost of compensating victims of medical malpractice and the administrative costs of the malpractice system. In addition, we undertook a comprehensive survey of the States to determine the status of medical malpractice law in each State and also examined a number of new reform proposals, many of which have not yet been tested.

THE CURRENT STATUS OF MALPRACTICE REFORMS IN THE STATES

In the past 15 to 20 years, virtually every State has enacted one or more medical malpractice reforms. In some States, several reforms were implemented as a packages. Charts 1 through 4 illustrate the extent of adoption of four kinds of reforms: caps on damages; changes in collateral source rules; implementation of pretrial screening panels; and restrictions on attorneys' fees.

Most of the malpractice reforms enacted by the states were a response to two malpractice insurance "crises," one in the mid 1970s and the second in the mid-1980s. The crises were marked by rapid increases in insurance premiums; in some cases, malpractice insurance was not available at any price. The objective of the reforms was mainly to lower the direct costs of the medical malpractice system and, hence, malpractice premiums.

Any reform that increases the cost of filing and pursuing a claim, raises the burden of proof for negligence, or reduces payments to successful plaintiffs should reduce direct malpractice costs and, other things remaining the same, malpractice insurance premiums. The reforms adopted by the States, at least in principle, did make it harder or more expensive to sue and lowered allowed payments when plaintiffs were successful in the courts. Some reforms, such as shortening the statute of limitations, limit access to the courts up front. Others may indirectly affect plaintiffs' access to the courts by making attorneys less willing to handle their claims (e.g., limits on attorneys' fees). By reducing allowed payments, caps on damages lower malpractice costs and may also reduce the frequency with which patients sue.

Though we can predict that the States' malpractice reforms reduce direct malpractice costs *in principle*, whether the reforms reduced direct malpractice costs *in practice* is an empirical question, because States enacted more or less stringent versions of each reform and some may not have been strong enough to reduce costs.

THE IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS

OTA analyzed the best studies available—a total of six[1] that evaluated which reforms, if any, reduced direct malpractice costs. Each of the six studies examined the impact of specific reforms on one or more indicators of direct malpractice costs, in-

[1] E.K. Adams, and S. Zuckerman, "Variation in the Growth and Incidence of Medical Malpractice Claims," *Journal of Health Politics, Policy and Law* 9(3):475–488, Fall 1984; D.K. Barker, "The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis," *Journal of Health Politics. Policy and Law,* 17(1): 143–161, Spring 1992; G. Blackmon, and R. Zeckhauser, "State Tort Reform Legislation: Assessing Our Control of Risks, " in *Tort Law and the Public Interest,* Peter H. Schuck (ed.) (New York: W.W. Norton & Co., 1991); P.M. Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary Problems* 49(2):57–84, Sprint 1986; F.A. Sloan, P.M. Mergenhagen, and R.R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," *Journal of Health Politics, Policy and Law* 14(4):663–689, Winter 1989; S. Zuckerman, R.R Bovbjerg, F. and Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," *Inquiry* 27(2): 167–182, Summer 1990.

cluding: the frequency of malpractice claims (measured as claims per 100 physicians); payments per paid claim; and malpractice insurance premiums. The reforms studied included:

- caps on damages;
- collateral source offsets
- limits on plaintiffs attorney fees;
- pretrial screening of claims for merit,
- periodic payment of large damage awards;
- shortening the statute of limitations;
- permitting the use of pretreatment agreements for binding arbitration;
- restricting the doctrine of joint and several liability.

Two reforms—caps on damages and mandatory offset of collateral sources of compensation—were found to consistently reduce one or more indicators of medical malpractice costs. Other reforms were found to have mixed results across studies (e.g., shortening the statute of limitations, pretrial screening panels). Some reforms showed no impact.

The failure to find an effect of some reforms on direct costs may result from several factors. First, these studies were not powerful enough to pick up effects that were very modest in size. For example, requiring periodic payments of damages over time would affect only the small percentage of awards that exceed $250,000, the typical threshold for this reform. Since savings from periodic payment versus lump-sum payment are modest, it may be difficult to detect an effect.

Second, the reforms as implemented were sometimes not very strong. For example, statutes imposing a cap on plaintiff attorneys' fees typically limited fees to one-third of the award—the average attorney fee absent reform. So, the "reform," if you want to call it that, merely codified current practice. It is no wonder that none of the studies reviewed by OTA found attorney fee limits effective in reducing the direct costs of malpractice.

Third, each State implements a reform of a given type with its own twist. When very different programs with very different effects are lumped together under a specific category, the effects of certain programs may be diluted in statistical analyses. Take, for example, pretrial screening. In some States, the findings of a pretrial screening panel are admissible in a subsequent trial; in others they are not. In some States, the panel makes a determination about damages; in others it is limited to determination of liability. These nuances are not captured in studies that lump together all pretrial screening programs.

Fourth, while States may have a reform on the books, the programs may be implemented only after a sometimes long delay. Legal challenges have delayed and sometimes overturned reforms that may nevertheless have been counted in the studies reviewed by OTA.

The bottom line is that we can say with some confidence that caps on damages and mandatory collateral source offsets will reduce direct malpractice costs. This is not surprising since limiting payouts by insurance companies should reduce payment per paid claim and may therefore lead to a decline in frequency of suit. Other reforms may reduce costs, especially when implemented as a package, but their impact may be quite modest compared with the impact of caps on damages or collateral source offsets.

NEW MALPRACTICE REFORM PROPOSALS

A number of malpractice reforms cannot be studied because they have not been tested. These include:

- the use of certain practice guidelines as the legal standard of care;
- encouraging mandatory binding arbitration;
- enterprise liability; and
- selective no-fault compensation.

Two of the reforms—use of clinical practice guidelines as a standard of care and enterprise liability—would leave malpractice cases in the judicial system. The objective of using clinical guidelines as a standard of care is to provide physicians with up front knowledge about the standard of care that a court will accept. This reform does not necessarily aim to reduce the direct costs of medical malpractice, except perhaps to discourage the filing of some non-meritorious suits. The State of Maine is currently conducting a 5-year demonstration project that makes certain practice guidelines available to physicians as a complete defense[2] to a malpractice claim.

[2] In Maine, certain practice guidelines can be used by physicians as an affirmative defense in a malpractice action. According to officials from Maine, this means that if the guideline is

Under enterprise liability, the institution in which the physician practices, or the patient's health plan, would be responsible for any malpractice claim made against the physician. Enterprise liability exists in certain HMOs and academic medical centers, such as the University of California medical hospitals. Enterprise liability may save some administrative costs because it consolidates the defense of a claim in one institution. Proponents also believe that enterprise liability will create more incentives for institutions to monitor the quality of care, perhaps leading to a reduction in the number of injuries. However, it was this potential monitoring that led the American Medical Association to oppose enterprise liability because of its potential to limit physician autonomy. In addition, some commentators believe that enterprise liability could lead to an increase in claims if patients feel more comfortable suing an institution instead of their physician.

Binding alternative dispute resolution and selective no-fault proposal would remove malpractice claims from the judicial system. Alternative dispute resolution (ADR) is a procedure in which a legal claim is resolved by a professional decisionmaker instead of a court. For example, many companies use arbitration to resolve claims. Binding arbitration is also used in some medical malpractice cases at the agreement of the parties. In fact, for close to twenty years, Kaiser Permanente has required its members in California and certain other States to agree to submit all medical malpractice claims to binding arbitration (OTA, 1993).

The American Medical Association and a group of more that 20 medical specialty societies has proposed a mandatory alternative dispute resolution system in which medical malpractice claims would be resolved by the State Medical Boards using an administrative procedure (AMA/SSMLP 1988). ADR may be less expensive administratively than proceeding to trial; however, since only a small percentage of today's malpractice claims proceed to trial, the impact on direct malpractice costs is unknown.

Selective no-fault proposals would designate certain adverse medical events automatically compensable through some type of administrative board. There would be noinquiry into whether the physician was negligent in caring for the patient (Tancredi, Bovbjerg, 1992). It is likely, however, that an alternative quality control system would be set up to monitor the number of compensable adverse events that occur. The impact on the direct costs of malpractice is unknown. On the one hand, such a system should result in many more patients receiving compensation for medically-caused injuries, including Injuries that would not be compensable under a fault-based system. On the other hand, the administrative costs of compensating this subset of medical injuries are likely to be lower than the tort system. In addition, the authors of the proposals recommend some limits on damages to accommodate the larger number of claims.

MALPRACTICE REFORM, DEFENSIVE MEDICINE AND HEALTH CARE REFORM

If the objective is to reduce health care costs, malpractice reforms that affect only direct costs will not make a dent. The direct costs of compensating patients injured by medical malpractice are less than 1 percent of health care costs overall. If medical malpractice reform is to lead to real cost savings, there will need to be reductions in the indirect costs of the medical malpractice system, primarily defensive medicine. Defensive medicine, as defined by OTA involves physicians' use of medical technologies to avoid the cost, disruption, and discomfort of being sued.

Whether and by how much physicians tailor their practices to avoid malpractice liability is the subject of OTA's final report for this assessment. To date, only one published study has documented a relationship between the extent of malpractice risk and the utilization of a medical procedure. This study found a markedly higher caesarean section rate by obstetricians practicing in hospitals in New York State in areas that experience high malpractice claim frequency or high malpractice insurance premiums (Localio, 1993). Whether this finding can be generalized to other specialties and States is unknown.

Proponents of some of the newer reform proposals, such as the enhanced use of clinical practice guidelines as the standard of care, enterprise liability, ADR, and selective no-fault, claim that each of these proposals has the potential to relieve physicians of some of the anxiety about a malpractice claim and may therefore lead to reductions in defensive medicine. The strengths and weaknesses of these arguments are discussed in detail in our final report. Suffice it to say, however, that the potential impact of these new reform proposals on physician behavior are based on logic, not experience.

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shown to apply to the situation and the physician followed the guideline, then the physician met the standard of care.

Medical malpractice reform is not being debated in a vacuum. It is being proposed as part of a comprehensive health care reform package that will likely have as one of its central goals to control rising health care costs. At present, the pressure to practice defensively occurs in a health care system that in large part imposes no financial penalty on doctors, and often compensates physicians when they use medical technologies. Under a different payment regime—for example a managed competition system—providers are likely to have an incentive to consider the costs of practicing defensive medicine against the opportunity to reduce their personal risk of suit. Physicians may therefore practice less defensive medicine even in the absence of tort reform. The impact of tort reform on defensive medicine and ultimately health care costs may be very dependent on the payment regime in which the tort reform is implemented.

MALPRACTICE REFORMS AND PATIENT ACCESS TO COMPENSATION

Some of the reforms that have a measurable effect on direct costs may be the reforms that most limit access for plaintiffs by reducing their potential award or placing the burden of cost-savings on the small percentage of plaintiffs who are most severely injured. While it is often stated that there are too many malpractice suits, and many interested parties may welcome reforms that limit access to the courts, recent evidence from New York State indicates that the overwhelming majority of patients injured by negligent medical care never sue (Localio, 1991). Moreover, this study shows that the frequency of negligent medical practices is not inconsequential.

In addition, certain reforms may have a disproportionate impact on access by low-income plaintiffs. As part of its assessment, OTA was asked to look at whether low-income plaintiffs, for example plaintiffs insured by Medicaid and Medicare, were less likely to sue for medical malpractice. The evidence demonstrates that they are much less likely to seek legal redress for injuries (Ehrenhaft, 1992). OTA also funded research by Laura Morlock, of John Hopkins University School of Public Health, to determine whether Maryland's passage of a law requiring plaintiffs to file a certificate of merit had a differential impact on access to the courts by plaintiffs with lower incomes (Morlock, 1993). A certificate of merit is essentially an affidavit from a physician or other expert that attests to the fact the plaintiff has a basis for their claim. In Maryland, a plaintiff may be required to pay between $500 and $1000 for a certificate of merit. Professor Morlock found that, subsequent to the implementation of the certificate of merit, there was a relatively much greater drop in the rate of malpractice suits filed by low-income plaintiffs (Morlock, 1993).

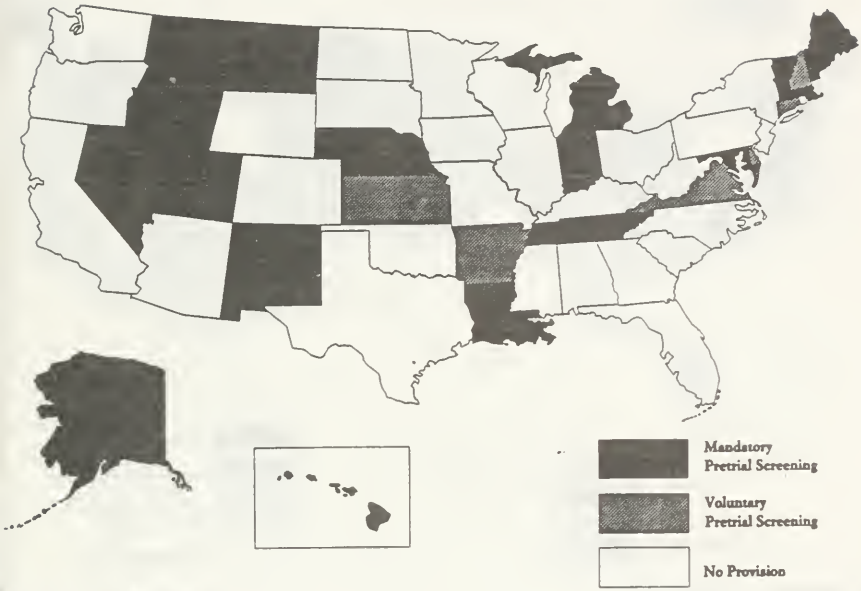
CONCLUSION

In sum, the best available evidence supports the conclusion that caps on damages and mandatory collateral source offsets will reduce medical malpractice costs. Other tort reforms may lead to reductions in direct costs, but their effect may be more modest. Since the direct costs of malpractice are only a very tiny fraction of the total health care budget, tort reforms that only impact direct costs are not going to have a substantial effect on total health care expenditures. One potential avenue for malpractice reforms to reduce health care costs is through a reduction in defensive medical practices. This is only possible if:

- defensive medicine adds significantly to health care costs, and
- malpractice reforms lead to a reduction in defensive medicine. OTA's final report will focus on these two questions.

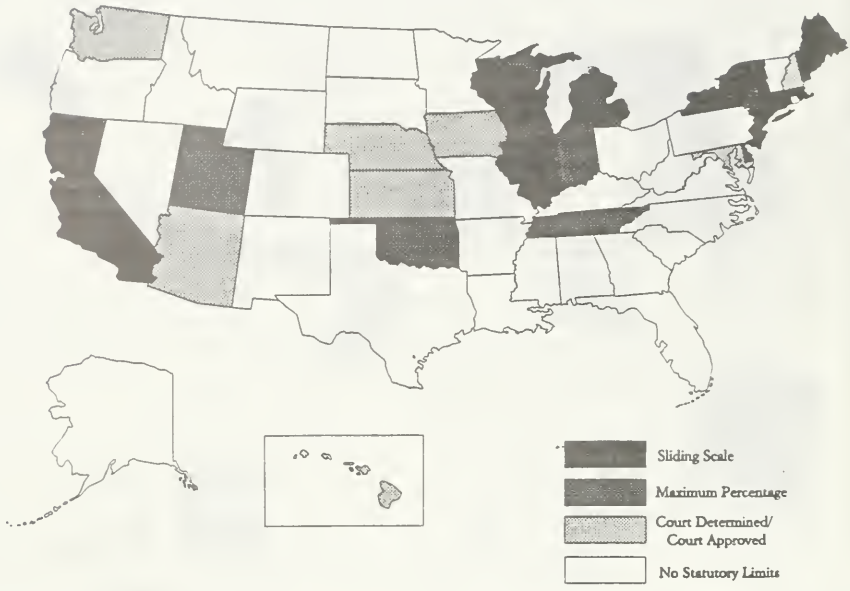
Finally, certain changes in malpractice law may have an adverse effect on the ability for certain patients to obtain compensation for medical injuries.

Chart 1--Pretrial Screening Panels for Medical Malpractice



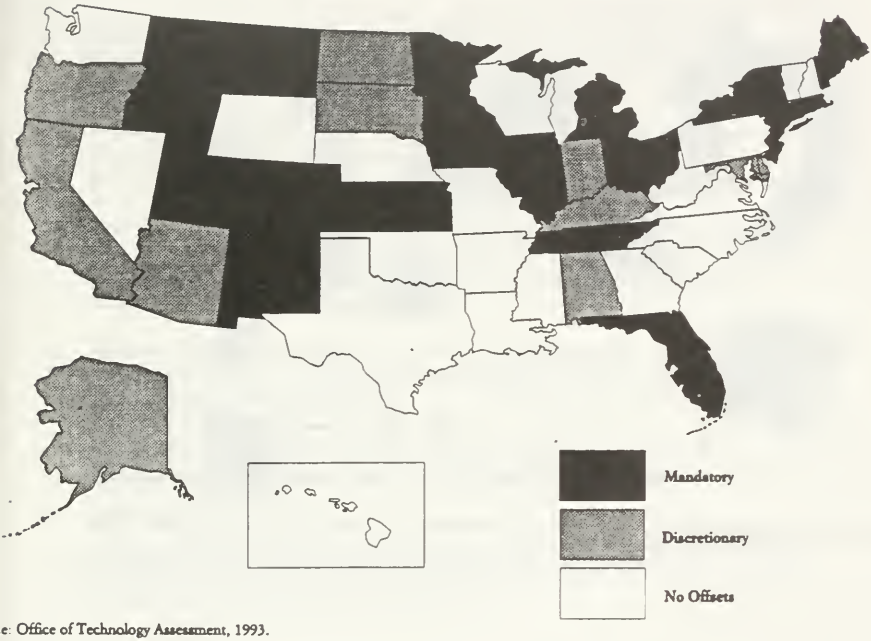
rce: Office of Technology Assessment, 1993.

Chart-2--Attorney Fee Limits



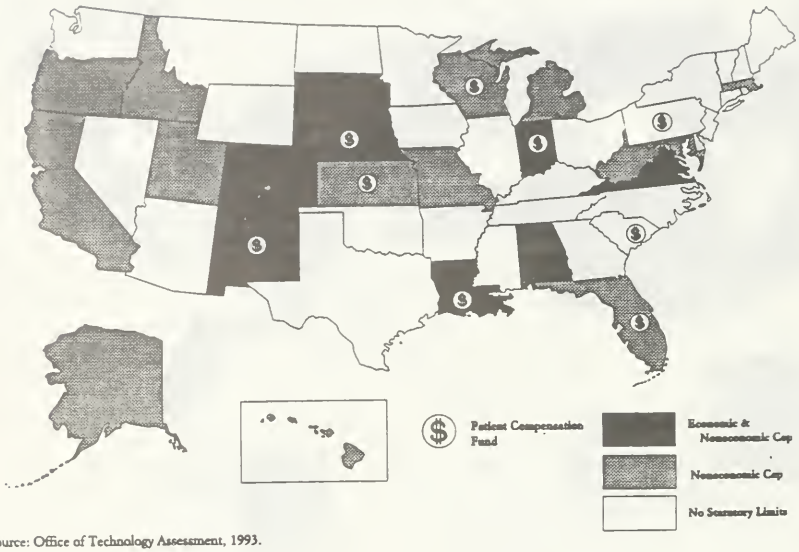
Source: Office of Technology Assessment, 1993.

Chart 3--Collateral Source Offset Provisions for Medical Malpractice Damages



e: Office of Technology Assessment, 1993.

Chart 4-Caps on Damages for Medical Malpractice



Source: Office of Technology Assessment, 1993.

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PREPARED STATEMENT OF SENATOR TOM HARKIN

Thank you, Chairman Moynihan, for giving Senator Hatfield and me the opportunity to testify before the Senate Finance Committee on behalf of our Fund for Health Research.

First, Mr. Chairman, I want to commend you for your leadership on health care reform and your long-term efforts in advancing the cause of medical research.

Unfortunately, the debate so far on health care reform has ignored medical research and its potential to increase quality of care and reduce long-term health care costs. In fact, in the debate about health care reform there has been a deafening silence when it comes to the role of medical research. Both the Administration and the Congress—to date—have failed to appreciate the role of research in enhancing quality as well as curbing long-term health costs.

I'm trying to change that. I joined with Senator Mark Hatfield in a bipartisan effort to ensure that any health care reform plan include significant additional funding for medical research.

Along with Bill Coyne, Bill Richardson, and Fred Upton in the House, we have introduced an amendment that would set-aside 1% of the cost of each health policy sold in this country into a medical research fund. When fully phased-in, this small set-aside would allow us to put between $4 and $5 billion into the fund and allow for nearly a 50 percent increase in funding for medical research.

Unlike all the other reform proposals, our amendment gets to the core of the problem of skyrocketing health care costs. Until we find the cures, or preventive measures for the diseases that are driving up the costs, we are only rearranging the deck chairs on the titanic.

Alzheimer's disease is a perfect example of why we need to invest in research. Four million Americans are currently living with Alzheimer's and medical and societal costs approach $100 billion a year. Yet our nation spends only $1 on Alzheimer's research for every $330 the disease is taking out of our nation's economy. The potential savings in just this one area are enormous.

Investment in research pays off. This past November scientists announced they may have linked a genetic risk factor for the most common form of Alzheimer's disease. If confirmed, this finding could lead to a simple diagnostic blood test, saving over $250 million a year, and could ultimately lead to a treatment for the disease, potentially saving as much as $50 billion annually in long-term care costs.

Yet, at a time when the biomedical sciences have entered an era of unprecedented opportunity, the percentage of research grant applications the NIH is able to fund has reached a ten-year low—we are able to fund less than 1 out of every 4 peer-reviewed grants.

Because of the budget agreement enacted last year, there is a 5-year freeze on discretionary spending. Therefore, what Congress can provide to the NIH through the appropriations process falls far short of the kind of increases necessary to allow our researchers to pursue emerging and significant research opportunities at the rate that would be most beneficial to society.

A dedicated funding source to add to annual appropriations is essential to speedy progress on illnesses like Alzheimer's, cancer, and other diseases, and to achieving effective, long-term health care cost control. That is why Senator Hatfield and I have proposed our amendment.

Public opinion polls demonstrate the American people support our idea. A recent poll by Lou Harris shows that 9 out of 10 Americans believe that this nation is not spending enough on medical research. And, not only do Americans want more spent on medical research but they are willing to pay for it—77% of Americans are willing to spend $1 more per week in insurance premiums.

We spend almost $1 trillion on health care in this country each year but only 2 to 3 percent is spent on research. The Defense Department spends 15 percent of its budget on research—that is why we have missiles that we can program to go down Main street and take a right on Fifth Avenue and then go into the third window from the right on the forth floor.

I believe that nothing short of a research buildup—similar to the defense buildup of the 80s—will yield an improved quality of life for all Americans. Through the Harkin/Hatfield amendment, we are moving a step closer to what we consider the ultimate goal—shifting our budget priorities from life-destroying programs to life-enhancing endeavors.

I believe that Americans are eager for comprehensive health care reform but they don't want quality to be compromised. We need to make sure that the health care provided in our nation continues to be of the highest quality in the world. The proposal that Senator Hatfield and I have put forward is critical to ensuring that this happens.

Our proposal is gaining momentum in Congress, and together we can make it a reality. More than 250 organizations have endorsed our proposal, and as represented on this panel today, our amendment enjoys truly bipartisan support in both the Senate and the House.

Mr. Chairman, Senator Hatfield and I are committed to adding our proposal to all health care reform bills considered by Congress this year. To this end, we request that you incorporate the Fund for Health Research in the health care bill that will be reported out of the Senate Finance Committee. I want to take the opportunity now to commend Senator Kennedy for incorporating our proposal in its entirety into the health care bill to be considered by the Senate Labor and Human Resources Committee.

We believe that increased funding for medical research is the best investment in ensuring quality and reducing our nation's long-term health care costs. Mr. Chairman, I know that you share with me the belief that health care reform without research is no reform at all.

HARKIN/HATFIELD FUND FOR HEALTH RESEARCH QUESTIONS AND ANSWERS

What does the proposal call for?

As a component of health care reform, a mechanism would be established to greatly enhance the quality of health care by investing more in finding preventive measures, cures and more cost effective treatments for 'the major illnesses and conditions that strike Americans. A National Fund For Health Research would be established to provide additional resources for health research over and above those provided to the National Institutes of Health (NIH) in the annual appropriations process. When fully phased in, approximately 1 percent of all the monthly health insurance premiums collected by corporate and regional alliances (or any other mechanism for collecting premiums) would be set aside and regularly transferred into a Fund For Health Research in a manner consistent with the set aside for graduate medical education and academic health centers proposed in the President's health care reform plan. This additional set aside should generate sufficient funds to provide for an approximately so percent increase in funding for the NIH.

Each year amounts within the Fund would automatically be allotted to each of the NIH Institutes and Centers. Five percent of the monies would be directed to extramural construction and renovation of research facilities, the National Library of Medicine, and the Office of the Director. So that an appropriate range of basic and applied research is supported, each Institute and Center would receive the same percentage of the remaining Fund monies as they received of the total NIH appropriation for that fiscal year. In order to insure that the additional funds generated do not simply replace regularly appropriated NIH funds, monies from the Fund would be released only if the total appropriated for the NIH in that year equal or exceed the prior year appropriations.

Additional monies for the Fund would be generated by a voluntary federal income tax check-off. Every year, when filing their Federal income tax returns Americans would be given the opportunity to designate tax overpayments and contributions for health research. Monies from the check-off would be deposited in the Fund.

Why is this proposal necessary?

Health research has brought us the advances in treatment and prevention of disease and disability that define our current high standards of medical practice and promises even more remarkable advances in the near future. Perhaps more than any other component of our health care system, it holds the promise of both reducing medical costs and improving quality. Yet, because the federal budget agreement freezes discretionary spending for the next four years, Federal funding for health research will likely not even keep up with inflation unless a separate funding stream is established. Health care reform offers the best opportunity to establish such a new stream.

What is the status of the Harkin/Hatfield proposal?

A formal amendment detailing the proposal was introduced February 28, 1994 by Senators Harkin, Hatfield, Kennedy and Kassebaum. Efforts will focus on having the proposal attached to any health care reform proposal reported out by the Committees and adopted by the full Senate. A similar proposal will be put forward in the House of Representatives by Representative Coyne and others. A hearing focusing on the Fund was held before the Senate Labor and Human Resources Committee on December 8, 1993.

Will the Fund simply replace existing monies appropriated to NIH?

No. Monies generated by the Fund would be in addition to, not in replacement of those provided to each of the NIH Institutes in the normal appropriations process. Monies from the Fund could not be allotted unless total NIH appropriations in that year were equal or greater than the prior year appropriations. Therefore, the Fund could not be used as a mechanism to replace or reduce regularly appropriated funds.

What is the relationship of the premium set-aside in the Harkin/Hatfield proposal to the set aside for academic health centers and graduate medical education in the Clinton health reform plan?

The two are separate and complementary. The graduate medical education and academic health center set aside will provide many important research institutions with needed support. However, this set aside does not directly fund health research. The Harkin/Hatfield proposal does.

How would money from the Fund be allocated among research priorities?

The proposal does not pick winners and losers among areas of health research. It does not interfere with the funding decisions made through the normal appropriations process. Funds would be allocated to each of the NIH Institutes and Centers based on the percentage that each of these entities received of the total NIH appropriation for that year. Monies allotted to each NIH entity would be Spent according to a plan developed by the entities' advisory council in consultation with the Director. Each Institute would decide the appropriate distribution of Fund monies among various research priorities within the Institute.

In recognition of the poor state of many medical research facilities, 2 percent of the total Fund would be taken off the top for extramural construction and renovation of research building and facilities. In accordance with traditional funding patterns, 1 percent of the total Fund would go to the National Library of Medicine. An additional 2 percent would go to the NIH Director for intramural construction and renovation and other activities supported by the Office of the Director.

How much support is there for the Fund for Medical Research?

The Harkin/Hatfield proposal has widespread support among the American people and among the health, health research and business communities. A Louis Harris poll released in December found that over 70 percent of Americans support such a plan. Support was strong across all age and income groups and in all regions of the country. In addition, over 200 organizations representing millions of Americans have endorsed the proposal. The fund has been endorsed by numerous Nobel Laureates, leading health care experts and business leaders.

PREPARED STATEMENT OF SENATOR MARK O. HATFIELD

UNITED STATES SENATOR • OREGON
Mark O. Hatfield

HATFIELD SAYS HEALTH CARE REFORM NEEDS MEDICAL RESEARCH COMPONENT

Senator Mark O. Hatfield
Testimony before The Senate Finance Committee
May 12, 1994

Let me begin by expressing my support for your efforts in dealing with one of the most complex issues of the day -- providing high quality health care to all Americans. While I do not envy your position, I do feel secure that the collective talent on this panel will lead to a legislative outcome which not only provides access to care, but provides for the highest quality of care we as a country can deliver to our citizens.

I am here today to share with you some good news to aid you in your task -- I bring a proposal which has strong bipartisan support and which has served as a rallying point in both the House and Senate, bringing together an array of cosponsors from those who favor single-payer approaches to health care reform to those who support managed competition. While we all have differing views on how to reform our delivery system, I am pleased to report that it appears that we are like-minded in our view that health research is a necessary and worthy investment. This proposal has now been endorsed by over 250 advocacy groups, and has earned the support of health dignitaries such as Former Surgeon General C. Everett Koop and Former Secretary of Health and Human Services, Dr. Louis Sullivan.

I'd like to take a moment to review with you the history of our proposal. Over the past several years, as the cry for health care reform has grown louder and louder, there has been a deafening silence when it comes to the role of medical research. Reformers are missing the point: health care reform will not be complete without a research component. It was a former Chairman of the Appropriations Committee, Senator Warren Magnuson, who said "medical research is the first link in the chain of prevention." Research is our first line of defense. It is our ultimate investment in preventing disease and disability. It is for this reason that I have joined Senator Harkin in endorsing the establishment of a National Fund for Health Research as part of any package which is billed as comprehensive health care reform.

Advancements in medical research offer hope to millions of Americans suffering from disease and debilitating disorders.

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This is particularly true for the 20 million people afflicted with one of the 5,000 rare diseases on which little to no research has yet been conducted. These people have only the hope that the promise of medical research provides.

Medical research is also a central mechanism for controlling the cost of health care in this country. After all, a cure is the ultimate in cost control. It is a key link in our strategy to find treatments and remedies which will finally drive down costs.

Currently the United States devotes less than 2% of total health care spending to the study of disease and disabilities -- in 1993, $12 billion out of a total federal health care budget of $290 billion. This is merely lip-service to the importance of medical research. If we can't view research as an investment in the long-term, we should at least look at it from our own self-interest. We need ultimate cost savings in our health care delivery system. Examples abound of research results translating into direct savings.

*The improved Hemophilus Influenza Type B vaccine saves $359.3 million annually for every group of children vaccinated. In contrast, the research cost only $17.4 million.

*Treatment of manic-depressive disorders by using lithium reduced health care costs by $6 billion between 1969 and 1984 - more than has been spent on mental research in the NIH's history.

*National Eye Institute research led to the development of a laser treatment for diabetic eye degeneration. The research cost $48 million, while the potential annual savings is estimated at more than $2 billion.

The United States has built an impressive biomedical research enterprise since the inception of the Marine Hospital Service over 200 years ago. Today, dramatic developments in genetics and gene therapy offer new hope to many suffering from disorders such as cystic fibrosis, sleep apnea, breast and prostate cancer, diabetes and Alzheimer's Disease. The federal government has a unique leadership role to play -- for example, the federal level is the appropriate place for an initiative like the Human Genome project, which seeks to create a complete "road map" of the human genetic structure. The return on this project through new cures, treatments, jobs and economic growth will ultimately overshadow the costs of the research.

It is very troubling to me that at a time when the biomedical sciences have entered such an era of unprecedented opportunity, fault lines are appearing in our research infrastructure. We seem to be disinvesting in medical research.

In fiscal year 1993, one of the first red flags appeared. The

Congress, for the first time since I have served in the Senate, appropriated less money for the NIH than the President had requested. The outlook for fiscal year 1994 was worse. The President's budget recommended funding below the previous year's level for 9 of the 19 NIH Institutes and Centers. While we were able to restore much of this funding, the signal this sent was unmistakable. For the current year, the Administration's request of a $517 million increase was cut in-half by the House in their version of the budget resolution. These funds appear to be seen as dispensible.

We need to repair these fault lines and bring stability to the very foundation of health care. As a member of the Appropriations Committee for over twenty years, I am convinced that this stability cannot be accomplished simply through the appropriations process. A dedicated funding source to augment annual appropriations is essential if we are to fulfill the hopes of millions of Americans suffering from disease and disability and achieve effective long-term health care cost control. Nothing short of a disease defense buildup will yield an improved quality of life for all Americans.

As policymakers, we are not alone in this task. Public opinion polls have shown massive public support for making health research the number one Federal science priority. Polls have shown that Americans favor an investment in medical research by a 30 to 1 ratio when compared to weapons research.

I'd like to share with you a recent example of the level of public education and awareness which is currently ongoing through independent organizations like the American Cancer Society. To enhance resources for breast cancer research, this group has put stamps in grocery store check out lines -- shoppers merely present a stamp to the checker and let them know the amount of the donation they which to make, which is then added to their grocery bill. In addition, printed information is available which gives further information about the disease, including warning signs.

It is this kind of activity which is essential to the success of our efforts. Our proposal calls for two funding sources -- a 1% setaside on health insurance premiums and a voluntary federal income tax checkoff. The tax checkoff, already included in Senator Chafee's HEART proposal, is based on a successful model in place in my state of Oregon. We have an income tax checkoff devoted to Alzheimer's Disease, which has helped to finance research and care. I am aware of the concern of creating a proliferation of tax checkoffs, and so we have included language in our proposal which requires that the checkoff raise a minimum of $5 million every two years in order to remain on the federal tax forms.

As this is the Finance Committee, I am also aware of the importance of sound figures when discussing proposals such as

this one. Senator Harkin and I have asked for an official reading from the Congressional Budget Office on the costs associated with this bill. Our own estimates indicate that the combined funding sources would yield between $4 - $5 billion a year in additional funding for the National Institutes of Health.

I'd like to raise one last point regarding academic health centers. Senator Harkin and I view our research proposal as complimentary to the payments needed to continue the work of our teaching hospitals. Fifty-one percent of all NIH dollars are currently being spent in academic medical centers. The two missions -- teaching and research -- go hand-in-hand. We believe a viable research component is critical to the future of academic medical centers.

Mr. Chairman, the facts are unmistakable. Biomedical research has been the success story of the 20th century -- between 1963 and 1987, deaths from cardiovascular disease fell 45% and coronary artery disease fell 48% -- both as a result of research. Rarely will we find a more direct influence on the outcome we seek -- a viable health care delivery system which delivers high quality care in an affordable manner -- depends on health research.

DHHS—NATIONAL INSTITUTES OF HEALTH
APPROPRIATIONS HISTORY

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation 1/
1981	$3,512,320,000	$3,572,427,000	$3,564,765,000	$3,569,406,000 2/
1982	3,310,985,000 3/	3,834,958,000	3,818,710,000	3,641,875,000 4/
1983	3,748,771,000	4,013,450,000	4,028,591,000	4,023,969,000 5/
1984	4,091,958,000	4,314,501,000 6/	4,322,912,000 6/	4,493,588,000 7/
1985	4,566,453,000	4,834,343,000 8/	5,170,203,000	5,149,459,000
1986	4,852,680,000	5,247,836,000 9/	5,463,658,000	5,498,454,000
1986 Sequester				(236,243,000)
1987	4,936,157,000 10/	6,152,775,000	6,080,875,000	6,182,910,000
1988	8,260,277,000 11/	7,036,285,000 12/	6,408,176,000	6,666,693,000
1989	6,535,207,000 13/	6,862,495,000 14/	7,199,298,000	7,152,207,000 14/
1990	6,776,727,000 16/	7,678,625,000 17/	7,713,064,000 17/	7,672,922,000 18/
1990 Sequester				(96,570,000)
1991	7,929,686,000	8,317,654,000 19/	8,347,085,000	8,276,739,000 20/
1991 Sequester				(107,000)
1992	8,774,886,000	8,824,886,000	8,978,133,000	8,921,687,000 21/
1993	10,579,684,000	10,368,551,000	10,387,721,000	10,326,604,000 22/
1994	10,667,984,000	10,936,652,000	10,956,389,000	10,955,773,000
1995	11,473,000,000 23/			

1/ Reflects enacted supplementals, rescissions and reappropriations.
2/ Authority was a Continuing Resolution; reflects a rescission of $47,041,000 authorized under P.L. 97–12.
3/ September budget; original request was $3,762,483,000.
4/ Continuing resolution was the lower of the House or Senate Allowance less a 4% reduction.
5/ Authority was a Continuing Resolution.
6/ Excludes $166,368,000 not considered.
7/ Includes $175,838,000 authorized under a Continuing Resolution.
8/ Includes $237,435,000 for NRSA training, not considered.
9/ Excludes $217,943,000 for NRSA training, not considered.
10/ Reflects transfer of AIDS research activities to OASH. The House allowance consolidated AIDS funding in the Office of the Director, NIH; the Senate allowance and the appropriation distributed the funding among the Institutes.
11/ Includes proposed advanced appropriation of $2,726,000 for outyear cost of competing RPGs in 1988.
12/ The House allowance consolidated AIDS funding in OASH.
13/ The 1989 request excludes funds for AIDS, proposed for consolidation in OASH.
14/ Excludes $249,464,000 not considered.
15/ Includes real transfer of $7,443 to OASH for AZT
16/ The 1990 request excludes funds for AIDS, proposed for consolidation in OASH.
17/ Includes $752,670,000 for AIDS research.
18/ Reflects reductions of $10,000,000 for extramural salary cap savings, $4,000,000 for procurement reform and a $10,428,000 reduction in salaries & expense.
19/ Excludes $304,814,000 not considered.
20/ Reflects enacted administrative reduction of $29,909,000 for salaries and expense and $205,134,000 associated with the 2.41 percent across the board reduction.
21/ Reflects enacted administrative reduction of $69,603,000 for salaries and expense a travel reduction of $5,984,000, and a rescission of $13,131,000.
22/ Reflects enacted administrative reductions of an across the board .8 percent for $83,571,000, $34,857,000 for salaries and expenses and a consultant services reduction of $1,342,000. All columns adjusted to include transfer from ADAMHA.
23/ Includes $1,379,052,000 for HIV Research proposed for consolidation in the NIH Office of AIDS Research.

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DHHS – NATIONAL INSTITUTES OF HEALTH

FY 1994 PRESIDENT'S BUDGET

(Dollars in Thousands)

	FY 1993 COMPARABLE			FY 1994			% CHANGE (94 VS 93 COMPARABLE)			
ICD	NON-AIDS	AIDS	TOTAL	NON-AIDS	AIDS	TOTAL	NON-AIDS	AIDS	TOTAL	ICD
NCI	$1,805,111	$173,230	$1,978,341	$1,928,965	$213,157	$2,142,122	6.9%	23.0%	8.3%	NCI
NHLBI	1,166,657	48,058	1,214,715	1,143,425	54,977	1,198,402	-2.0%	14.4%	-1.3%	NHLBI
NIDR	152,855	8,286	161,141	151,578	11,431	163,009	-0.8%	38.0%	1.2%	NIDR
NIDDK	673,856	6,804	680,660	666,697	10,438	677,135	-1.1%	53.4%	-0.5%	NIDDK
NINDS	581,211	18,266	599,477	567,960	22,105	590,065	-2.3%	21.0%	-1.6%	NINDS
NIAID	528,713	459,697	988,410	520,792	544,791	1,065,583	-1.5%	18.5%	7.8%	NIAID
NIGMS	815,385	16,850	832,235	809,717	23,347	833,064	-0.7%	38.6%	0.1%	NIGMS
NICHD	490,209	37,543	527,752	485,931	56,426	542,357	-0.9%	50.3%	2.8%	NICHD
NEI	269,715	6,198	275,913	263,820	8,381	272,201	-2.2%	35.2%	-1.3%	NEI
NIEHS	246,808	4,379	251,187	255,698	5,608	261,306	3.6%	28.1%	4.0%	NIEHS
NIA	398,414	1,114	399,528	392,492	1,664	394,156	-1.5%	49.4%	-1.3%	NIA
NIAMS	210,448	1,795	212,243	207,587	2,795	210,382	-1.4%	55.7%	-0.9%	NIAMS
NIDCD	153,768	1,007	154,775	151,581	1,507	153,088	-1.4%	49.7%	-1.1%	NIDCD
NIMH	503,977	79,145	583,122	488,833	87,182	576,015	-3.0%	10.2%	-1.2%	NIMH
NIDA	277,060	127,123	404,183	263,722	143,376	407,098	-4.8%	12.8%	0.7%	NIDA
NIAAA	168,370	8,072	176,442	163,305	9,310	173,615	-2.4%	15.3%	-1.6%	NIAAA
NCRR	261,776	50,881	312,657	266,504	61,383	327,887	1.8%	20.6%	4.9%	NCRR
NCNR	45,224	3,272	48,496	44,531	4,444	48,975	-1.5%	35.8%	1.0%	NCNR
NCHGR	106,134	0	106,134	134,549	0	134,549	26.8%	0.0%	26.8%	NCHGR
FIC	14,031	5,684	19,715	11,136	8,852	19,988	-20.6%	55.7%	1.4%	FIC
NLM	111,904	1,101	113,005	130,267	3,082	133,349	16.4%	179.9%	18.0%	NLM
OD	175,577	14,757	190,334	209,163	25,744	234,907	19.1%	74.5%	23.4%	OD
B&F	108,731	0	108,731	108,731	0	108,731	0.0%	0.0%	0.0%	B&F
TOTAL	9,265,934	1,073,262	10,339,196	9,367,984	1,300,000	10,667,984	1.1%	21.1%	3.2%	TOTAL

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman: Thank you very much for making the Committee's time available to hold this hearing on two critical issues connected with health care reform: medical malpractice and antitrust.

As you know from our discussions, I believe very firmly that legislation is needed in both these areas. I am hopeful today's examination will provide us with a springboard from which we can begin drafting provisions.

I know not all of the members of the Committee may share that viewpoint, but I hope that our discussion here will help convince everyone that action on medical malpractice and antitrust reform are needed, and needed now.

It is fitting that these topics should be discussed together. Both concern costly regulation of the health care market which add to the cost of providing health care services.

Unlike most regulation, however, the regulation in these areas is left largely to the courts, where decision-making is incremental, often unpredictable, and always expensive. Not only are the costs of losing exceptionally high—malpractice awards in the millions of dollars are commonplace, and antitrust suits threaten triple damage awards—even the costs of winning malpractice, and especially antitrust suits, are extraordinarily high.

The unpredictability of outcomes adds to the costs of doing business. And the results are often inconsistent, not just across jurisdictions—further adding to the difficulties encountered by multi-jurisdictional providers—but sometimes even within jurisdictions.

As we discuss ways of streamlining the delivery of health care services in ways that reduce the costs to consumers, we must address malpractice and antitrust systems which add to the spiralling costs of the health care system.

Malpractice reform generally receives greater attention because of stories of individual doctors and patients with concrete injuries appeal to our imaginations. We can easily sympathize with the doctor wrongly accused or the patient wrongly injured. While more arcane, perhaps, antitrust is no less important a candidate for cost-saving reform.

Stories of small rural hospitals, attempting to merge to reduce wasteful duplication and litigating for five years, should disturb all of us who are serious about reducing unnecessary costs of providing health care.

In my own home state of Utah, a number of hospitals and providers—including the state university's teaching hospital—spent millions of dollars defending against a Justice Department fishing expedition which ended with a settlement that can only be described as face-saving.

Now that that has been resolved, the Federal Trade Commission is in Utah reviewing the actions of some other hospitals. Whatever the right outcome of these cases, surely we can devise less costly methods of resolution! The millions of dollars spent on antitrust actions in Utah—many of them state taxpayer dollars—would have better been spent on providing health care to patients.

We must be able to find a way to adjust the system so that fewer of the dollars now going to lawyers to resolve antitrust and malpractice disputes instead go to caring for patients.

As my contribution to the debate on these antitrust issues, I have introduced with Senator Thurmond and others an antitrust proposal, S. 1658, The Health Care Antitrust Improvements Act of 1993, which has been included in both Senator Chafee's and Senator Nickles' comprehensive health care proposals. It is a modest framework for harmonizing the antitrust laws with whatever final health reforms eventually come out of the Congress.

I have attached to my testimony a summary of this legislation.

Antitrust is a system of regulation whose administrative costs sometimes make the cure worse than the disease. Antitrust decision-making can be simplified, streamlined, and focused to ensure that the costs of the system itself deter fewer pro-consumer or harmless arrangements and that scarce enforcement resources are deployed to review truly troubling activities.

Most importantly, the antitrust system can be fine-tuned to encourage, rather than deter, innovative and cost-saving collaborative arrangements among providers which can lead to better quality services and lower costs to health care consumers.

S. 1658 seeks to accomplish this through a three-part framework which builds on established and non-controversial components.

Because antitrust analysis is very fact-intensive, the heart of our proposal is a case-specific review procedure similar to what the enforcement agencies now perform in the business review letter process.

Antitrust attorneys tell me that clients invariably ask if they can get pre-approval from the antitrust enforcers before they invest substantial resources in a venture that might be challenged later. Those attorneys usually respond that the only type of pre-approval is a business review that may take years to get and which, even if granted, provides almost no assurance of safety.

States have been responding to this problem by enacting a range of state waiver systems which purport to immunize providers from both state and federal antitrust laws. At least 14 states have passed such laws in the last two years including New York, Montana, Maine, North Dakota, Kansas, Minnesota, and Ohio.

The antitrust agencies have recently committed themselves to making the business review process more user-friendly and more timely, promising a 90-day response period. Our proposal accepts the agencies' proposition and establishes a 90-day review process.

We believe, however, that the review process should be given legal effect. Our proposal is based on the Export Trading Company Act, under which the Commerce Department grants antitrust immunity to collaborative arrangements for exporters.

A business review letter is not worth much more than the stamp on its envelope because it is advisory only; it does not bind private parties, state enforcers, or even the agencies themselves—and there are two separate federal antitrust enforcement agencies.

We propose that if the Attorney General finds that the case warrants it, the collaboration in question be granted a waiver from the antitrust laws, subject to yearly reporting requirements to ensure that approved transactions are not later misused.

I am told by attorneys for small managed care entities that such a pre-approval process would be of substantial benefit to their clients. One small managed care company in New York state recently won, not lost, but won, an antitrust suit at a cost of about a half-million dollars. A few victories like that and such companies will be out of business. A pre-approval that precludes such costly suits can help encourage small competitive, cost-efficient health care providers.

Such comprehensive reviews to obtain waivers are themselves costly. In order to reduce the incentives to file for a waiver, S. 1658 contains two further mechanisms to streamline antitrust decision-making and encourage pro-competitive or harmless collaboration.

There will be certain types of arrangements or transactions which are easy cases or which nearly always gain approval. For such cases, we employ the concept of safe harbors, based on the antitrust agencies' policy statements released last year.

Furthermore, we direct the Attorney General to develop other safe harbors, as appropriate, as she receives input from the public and as she gains experience with the review process.

Second, we apply the principles of the successful National Cooperative Research Act ("NCRA") to the health care market. Under this provision, providers may file a disclosure of parties and activities with the Attorney General and receive reduced potential antitrust liability, namely single rather than triple damages and the opportunity to make their justifications under a rule of reason analysis rather than having their venture condemned categorically under per se rules. This mechanism provides reduced risks at minimal cost.

The combination of case-specific review and safe harbors for easy cases is the approach the antitrust agencies enthusiastically endorsed last year in their policy statements. The addition of the reduced damages under NCRA principles also follows successful precedent.

It should be pointed out that we did not simply codify the agencies' policy statements, but used the general concepts and numerous specifics as a starting point. We simplified or broadened some safe harbors to make them more useful.

While some may differ with the particular lines we have drawn, we believe the approach is a sound framework for developing a more responsive and less costly antitrust system.

In the malpractice area, I am currently finalizing a no-fault based proposal which I will introduce in the next few days. This could also help reduce the costs of the malpractice system.

It would provide a system whereby either the provider or the patient could choose to settle the amount and expedite payment of the economic damages suffered by an injured patient. This system would allow expedited payment without costly legal wrangling about fault, causation and damages.

Also, by eliminating the collateral source rule, the cost of injuries would be covered first by the individual's own insurance and then by the doctor's malpractice insurance. This will help reduce the cost of malpractice insurance.

The issue of punitive damages would still be dealt with in court, but punitive damages would be capped and decided by the judge, not the jury.

In addition, my bill, which benefitted from the input of Dr. Brennan who will testify today; will allow states to experiment with true no-fault systems.

In Utah, a number of providers are collaborating with Dr. Brennan to design a no-fault plan in which a patient can be paid a predetermined amount upon a showing that he or she had a bad result from medical treatment. The notion of fault would be completely dispensed with, eliminating any need for litigation costs.

I am very enthusiastic about the work Utah is doing to design this system and think it can provide a model for the whole nation.

I want to thank Mr. Weintraub for making his time available at the last minute to testify on behalf of our bill, and also Dr. Corlin who will provide us with many insights.

I look forward to the testimony of Ms. Corrigan from OTA who will discuss a report on defensive medicine that Congressman Archer and I requested last year. We are working very closely with Representative Archer on both these issues and his leadership in the House should be recognized.

In summing up, let me reiterate that I believe these are two areas in which Congress can make significant contributions to reducing unnecessary costs that burden our health care system. Reasonable change in these areas would go a long way to encouraging the kinds of cost-savings the American people want, and that the American health care system can provide.

I want to comment briefly on the issues that our colleagues Senator Tom Harkin and Senator Mark Hatfield will raise with respect to funding for biomedical research. We simply have to find a way to get more money into research at NIH, and they have come up with a very creative proposal which deserves serious attention.

Thank you Mr. Chairman.

SECTION-BY-SECTION OF S. 1658, THE HATCH-THURMOND HEALTH CARE ANTITRUST IMPROVEMENTS ACT

Senators Hatch and Thurmond introduced the Health Care Antitrust Improvements Act, S. 1658, on November 10, 1993. A companion bill was introduced in the House of Representatives the same day by Ways and Means Ranking Republican Bill Archer (H.R. 3486).[1]

Subsequently, the 37-page antitrust bill was fully incorporated into two major health care reform proposals, the Health Equity and Access Reform Today Act (Chafee)[2] and the Consumer Choice Health Security Act (Nickles-Hatch).[3]

The Hatch-Thurmond bill establishes a framework for adjusting the antitrust laws to changing health care markets. In the absence of such legislation, much of the other substantive health care reforms could run into antitrust objections or challenges. This would result in desirable conduct by health care providers being chilled due to actual or perceived levels of antitrust risk.

The Hatch-Thurmond bill provides three types of antitrust adjustments for evolving health care markets:

- Safe harbors for listed categories of conduct and a process for developing additional safe harbors.
- Case-by-case waivers by the Attorney General for specific conduct based on stated criteria.
- Actual (rather than treble) damages and Rule of Reason analysis (comparing pro-competitive and anti-competitive effects) for collaborative activities which are disclosed to the Attorney General, if they are later challenged.

The bill contains safeguards requiring the Attorney General periodically to review the safe harbors and waivers and report to Congress, to ensure that the act continues to serve its intended purpose. The bill also imposes annual reporting requirements on those granted waivers and permits termination of waivers.

Section 1. SHORT TITLE.

The bill's short title is the Health Care Antitrust Improvements Act of 1993.

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[1] The Archer bill contains two notable differences from the Hatch-Thurmond bill: the market power threshold screen in the Archer bill is 25% rather than 20% in Section 3(1); and the Archer bill has a broader definition of cooperative ventures which are deemed to have filed a written notification under Section 6(a)(2).

[2] S. 1770, the Health Equity and Access Reform Today Act of 1993, was introduced on November 22, 1993 by Senator Chafee and 17 co-sponsors. The Hatch-Thurmond bill is incorporated as Title IV, Subtitle C.

[3] S. 1743, the Consumer Choice Health Security Act of 1993, was introduced on November 20, 1993 by Senator Nickles and 24 co-sponsors. The Hatch-Thurmond bill is incorporated as Title VI.

Section 2. ANTITRUST EXEMPTIONS FOR CERTAIN HEALTH CARE ACTIVITIES.

Health care related activities are exempt from federal and state an ti trust laws if they come within a safe harbor listed in Section 3 of the bill, come within an additional safe harbor designated pursuant to Section 4, or are covered by a specific antitrust waiver, called a certificate of review, under Section 5.

Certificates of review will be granted on a case-by-case basis by the Attorney General. Certificates granted during the first two years after enactment of the bill will retroactively cover activities within the two year period prior to issuance of the certificate.

Section 2(b) provides that a court is to award the defending party its costs and attorneys' fees for any frivolous or unreasonable antitrust action which is brought against exempt activities. However, an award of costs and attorneys' fees may be offset if the prevailing party's conduct in litigation was frivolous or unreasonable.

Section 3. DESCRIPTION OF SAFE HARBORS COVERING SPECIFIC CATEGORIES OF CONDUCT.

Seven categories of conduct are defined as safe harbors which are exempt from federal and state antitrust laws. Several of these are based on the *Statements of Antitrust Enforcement Policy in the Health Care Area* jointly issued by the Department of Justice ("DOJ") and Federal Trade Commission ("FTC") in September 1993, which provide "safety zones" for certain categories of conduct that generally will not be challenged by the two agencies. The safe harbors of the Hatch-Thurmond bill are broader and provide more certainty than the safety zones in the DOJ/FTC Statements, which have no legal effect on courts; no effect on private antitrust challenges, no effect on state antitrust enforcement, and even allow DOJ and FTC challenges of activities within a safety zone if there are "extraordinary circumstances."

The safe harbors are:

(1) *20% Market Power Screen.* All health care related activities by combinations of providers comprising 20% or less of the relevant product and geographic markets are exempt.

(2) *Medical Self-Regulatory Entities.* Standard setting and enforcement activities by medical self-regulatory bodies (such as hospital boards and medical societies) to promote health care quality are exempt, unless done for financial gain.

(3) *Participation in Surveys.* Health care providers may lawfully participate in written surveys of prices of services, reimbursements received and employee compensation, as long as a third party (such as a trade association) conducts the survey, the data is more than three months old, and the survey results are adequately aggregated before dissemination.

This safe harbor expands the safety zone for hospital surveys in the DOJ/FTC Statements to all health care providers.

(4) *High-tech Joint Ventures.* Activities of joint ventures to purchase and use or provide high technology or costly equipment and services are exempt as long as the health care providers included in the venture are necessary to its financial viability. Other providers not needed for viability may be included in the venture if they are unable financially to support a separate competing venture.

This safe harbor expands the safety zone for high-tech equipment ventures in the DOJ/FTC Statements to include other costly equipment and services.

(5) *Small Hospital Mergers.* Two hospitals may lawfully merge under the antitrust laws as long as one of them had no more than 150 operational beds on average over the last three years and inpatient censuses of less than 50% of that number.

This broadens the safety zone in the DOJ/FTC Statements which permits mergers between general acute-care hospitals where one averaged less than 100 licensed beds and 40 inpatients over the last three years.

(6) *Joint Purchasing Arrangements.* Health care providers may purchase jointly as long as their purchases are less than 35% of the total amount of the product or service purchased in the relevant market, and the cost of the jointly purchased items is less than 20% of the revenues from all products and services sold by the joint purchasers involved.

The terms of this safe harbor are identical to a safety zone in the DOJ/FTC Statements.

(7) *Good Faith Negotiations.* Good faith negotiations to initiate or engage in activities defined as safe harbors, additional safe harbors, or which are the subject of an application for a certificate of review are exempt from the antitrust laws.

Section 4. DEVELOPMENT OF ADDITIONAL SAFE HARBORS.

Within 30 days of enactment of this bill, the Attorney General is to solicit proposals for additional safe harbors covering health care activities which should be ex-

empt from the antitrust laws. Within 180 days of enactment, the Attorney General in consultation with the FTC Chairman and the Secretary of the Department of Health and Human Services ("HHS") is to review the proposals, report to Congress on which proposals have been accepted, and publish them in the Federal Register. Within 180 days after publication, the Attorney General is to issue final rules for the additional safe harbors (in the absence of action by Congress).

Section 4(b) provides that additional safe harbors are to be based on the following criteria: (i) the extent to which the activity increases access to health care, enhances quality, improves utilization, and provides cost efficiencies for the benefit of consumers, and (ii) whether health care providers and purchasers will be better able to negotiate arrangements to reduce costs to consumers, whether competition will be unduly restricted or foreclosed, and whether less restrictive alternatives exist.

Section 5. PROCEDURES FOR CASE-BY-CASE ANTITRUST WAIVERS.

The competitive impact of many arrangements cannot be determined without analysis of the specific facts involved, so the bill establishes a process in which certificates of review are given to health care providers for desirable conduct which meets the criteria set forth in Section 4(b) of the bill. This improves upon DOJ's system of providing business review letters and the FTC's advisory opinions on the legality of proposed actions under the antitrust laws, by providing full protection from private antitrust challenges and state enforcement agencies, as well as the federal agencies (which legally are not bound by their own advisory opinions), so that health care providers can proceed in confidence with approved transactions.

Within 180 days of enactment, the Attorney General in consultation with the FTC and HHS is to begin issuing certificates of review and assisting in the application process.

Applicants for certificates must specify activities which satisfy the criteria in Section 4(b), set forth above. Federal Register notices are required for each application and each decision to issue, amend or revoke a certificate. Applicants may seek expedited action, but certificates may not be issued until 30 days after the Federal Register notice.

The Attorney General, with the concurrence of HHS, is to issue a certificate within 90 days of receiving an application if the activities to be covered satisfy the Section 4(b) criteria and the benefits from the proposed activities outweigh any disadvantages from reduced competition. The certificate must specify the health care activities covered, the person covered, and any other terms and conditions. Applications are deemed approved if they are not rejected by the Attorney General within 90 days. Certificates are void ab initio if procured by fraud.

The Attorney General must provide the reasons for any denial to the applicant. Requests for reconsideration may be made within 30 days of denial, and the Attorney General (with HHS concurrence) must act on such requests within 30 days.

An annual report is required from each certificate holder describing the activities within the scope of the certificate during the previous year. Holders must report changes relevant to the certificate and may submit an application to amend the certificate under the usual procedures.

The Attorney General may revoke certificates based on: failure within two years to accomplish the purposes for which the certificate was issued, failure to comply with any terms or conditions of the certificate, or the activities covered no longer satisfy the criteria in Section 4(b), set forth above. The Attorney General may request information from the certificate holder to determine whether grounds for revocation exist. Upon written notice, the Attorney General may revoke or modify a certificate to cover only activities which meet the requirements for issuance of certificates.

Denials of certificates and revocations are reviewable in federal court on a preponderance of the evidence standard. Denials or revocations and the reasons underlying the decisions are not admissible in other antitrust actions.

If an application is denied, supporting documentation must be returned upon request. Information relating to certificates of review are exempt from FOIA requirements and must not be disclosed by the government except in limited circumstances, such as a request of Congress.

The certificate of review process is based broadly on the Export Trading Company Act of 1982 (15 U.S.C. §§4001–21).

Section 6. REDUCED DAMAGES FOR DISCLOSED COLLABORATIVE ACTIVITIES.

This section provides for actual, rather than treble, damages and application of the Rule of Reason standard (which compares the pro-competitive and anti-competitive effects of conduct) to all collaborative health care activities which are disclosed

to the Attorney General, if they are later challenged under the antitrust laws. This approach has been used successfully for research & development joint ventures in the National Cooperative Research Act of 1984 ("NCRA," 15 U.S.C. §4301, et seq.). NCRA was expanded to cover production joint ventures by the National Cooperative Production Amendments Act of 1993 (Pub. L. No. 103§42), but the 1993 legislative history states that the "bill's protections will not extend to joint ventures to provide what are simply services, such as health care or legal services, that are unconnected to any concrete technological innovations, or to joint ventures solely to purchase medical equipment." (Senate Report 103–51 at 9.)

The concept, which has been validated by NCRA over the last decade, is that those intending to unlawfully conspire will not notify the Attorney General because of the likelihood of prosecution, including possible criminal penalties and even imprisonment for some antitrust offenses. On the other hand, those who seek to engage in lawful collaborative ventures will be able to obtain the benefits of this section by a simple filing, so that economically desirable conduct will not be deterred by the risk of treble damages.

A health care cooperative venture will be subject only to actual, rather than treble, damages and analysis under the Rule of Reason (rather than per se) standard in any subsequent an ti trust challenge, if it submits a notification to the Attorney General disclosing the parties involved and the nature and objective of the venture. Notice about the venture must be published in the Federal Register.

A separate written notification is not necessary to obtain the benefits of this Section for (i) an applicant for a certificate of review under Section 4, or (ii) non-institutional health care providers in a nonexclusive network of less than 50% of the providers in the relevant market, or an exclusive network of less than 35%, as long as there is substantial financial risk-sharing within the venture.

The venture must submit information about changes in its membership. At any time the Attorney General may request additional information about the venture, which is exempt from disclosure under FOIA and must not be made publicly available by any agency except in judicial proceedings.

In litigation over activities which are covered by a notification, the court is to award costs and attorneys' fees to the successful claimant in all cases and to the successful defendant only if the claim or the claimant's conduct was frivolous or unreasonable. The fact of notification and information submitted are admissible only to obtain the benefits of this section.

Section 7. ATTORNEY GENERAL'S REVIEW OF EXEMPTIONS AND RECOMMENDATIONS TO CONGRESS.

The Attorney General in consultation with the FTC and HHS is periodically to review and recommend appropriate changes in the safe harbors (Section 3) to Congress, issue appropriate proposed revisions to the additional safe harbors (Section 4), and submit a report to Congress on certificates of review and their effectiveness in increasing access to high quality health care at reduced costs, as well as provide recommendations for any legislation needed to improve the certificate of review process.

Section 8. PROMULGATION OF RULES, REGULATIONS AND GUIDELINES.

The Attorney General with the concurrence of HHS is to promulgate rules, regulations and guidelines to carry out the provisions of the bill. In addition, the Attorney General is to issue and periodically update guidelines to assist health care providers in analyzing what activities may be within a safe harbor or suitable for a certificate of review.

Section 9. CREATION OF HHS OFFICE OF HEALTH CARE COMPETITION POLICY.

An Office of Health Care Competition Policy is created within HHS to handle competitive issues in health care.

This section is based on Section 4003 of the Export Trading Company Act of 1982, which created an Office of Export Trade within the Department of Commerce.

Section 10. DEFINITIONS.

Among other definitions, the term "antitrust laws" includes unfair competition law in addition to traditional antitrust law, and all comparable state laws. "Provider" is defined broadly as any person or entity required to be licensed by a State to provide health care services. A "specialty" is also determined according to state licensing requirements.

PREPARED STATEMENT OF SENATOR HOWARD M. METZENBAUM

Chairman Moynihan, and Members of the Committee. When I appeared before you last may, a number of members, including Senators Rockefeller, Baucus and Daschle, told me that hospitals were having difficulty with the antitrust laws. I acted on those concerns, and four months later the department of justice and the Federal Trade Commission ("FTC") published guidelines addressing hospitals' most pressing questions. The American Hospital Association thanked me publicly for my leadership on this issue.

Today, the senate is preparing to meet the challenge of health reform. I know firsthand that our health care system is a mess and that fixing it won't be easy. However, I am convinced that we could make the situation even worse for consumers if we relax our antitrust laws for doctors or hospitals.

For that reason, I am opposed to the antitrust exemptions in the administration's reform bill and the bill sponsored by Senator Chafee. Although the exemptions in the bills differ, both would permit doctors and other providers to fix prices and boycott patients.

The exemption in the Health Security Act gives doctors and other providers blanket antitrust immunity to collude on prices and then "negotiate" those prices in order to develop a payment schedule. Although the exemption might appear limited, I believe that it will increase the cost of health care for consumers under both fee-for-service and managed care plans.

I am not alone in this view. An extraordinary coalition of groups, including the American Association of Retired Persons, the Consumer Federation of America, the American Nurses Association, the Federation of American Health Systems, the Group Health Association of America and the major health insurance companies is opposing those exemptions. Frankly, I don't believe there is one other health issue on which all of these groups

Could agree except antitrust. I will submit their letter for the record.

The only sector of the health care industry that is not represented on the letter is doctors. That is because the AMA has made winning antitrust concessions its number one legislative priority. the so-called antitrust "relief" that the AMA is asking for may sound modest. It is not. To quote an April 11th U.S News & World Report article, "the changes that the AMA seeks sound like legal minutiae, but they represent major departures from current [antitrust] law." I urge you to reject them.

Make no mistake, allowing doctors, hospitals or other providers to collude and fix prices is bad medicine for consumers. although the hospitals do not favor exemptions, let me give you an example of how collusion can raise prices. Independence Blue Cross of Philadelphia told the Antitrust Division that its costs were $57 million higher when the State required it to negotiate prices with a large group of hospitals. The company estimated that in five years it would save over $500 million from individual negotiations.

The antitrust exemptions in Senator Chafee's bill would also raise prices for consumers. The coalition I just described has opposed the Chafee exemptions and their mirror image, S. 1658, sponsored by Senators Hatch and Thurmond. Only yesterday, I received a letter from the State Attorneys General opposing the exemptions. The Department of Justice has also opposed them on the grounds that they are "unnecessary and potentially harmful."

The fact is, the Chafee and Hatch exemptions would undermine antitrust enforcement by:

—creating antitrust loopholes for medical cartels;

—conferring permanent immunity on any health care deal that the Justice Department failed to block in 90 days;

—requiring the justice department to obtain clearance from the Department of Health and Human Services before approving a health care deal;

—authorizing costly federal court appeals by disappointed applicants for antitrust immunity; and

—reducing antitrust penalties for anticompetitive joint ventures.

my view is that provider cartels are more likely to stall health care reform than vigorous enforcement of the antitrust laws. As I stated previously, if there ever was a problem, the Justice Department and the FTC dealt with it last September. The agencies published guidelines to explain antitrust enforcement to providers and promised a 90-day review of health care deals. So far, 11 deals have been reviewed and none have been challenged. The guidelines have worked well, and I intend to urge the agencies to update and expand them. I am confident they will respond.

To be frank, I would be more willing to consider antitrust relief if providers could show me that those laws blocked procompetitive deals that would benefit consum-

ers. neither I nor the American people would support antitrust exemptions that created medical cartels that served no purpose other than to increase prices.

For now, I am convinced that the only change that we need to make in the antitrust laws to speed health reform is to revoke the McCarran-Ferguson exemption for health insurers. That change, which is included in the Health Security Act, would prevent insurance companies from fixing the price and the terms of health care coverage. I urge you to support that reform.

Attachment.

APRIL 27, 1994.

Hon. HOWARD M. METZENBAUM, *Chairman,*
Subcommittee on Antitrust, Monopolies, and Business Rights
Committee on the Judiciary
U.S. Senate
Washington, DC

Dear Mr. Chairman: As Congress considers health care reform legislation, we are writing to express our opposition to the creation of statutory antitrust exemptions, such as those proposed in the President's "Health Security Act" and in S. 1658/H.R. 3486, the "Health Care Antitrust Improvements Act of 1993." These exemptions would inhibit competition and harm consumers by increasing costs and impeding innovation in health care delivery.

Current antitrust laws are intended to preserve competition and promote consumer welfare. As such, these laws are crucial to achieving two critical goals of health care reform: 1) to provide consumers with affordable, high-quality care and 2) to promote the efficient delivery of services. Expanding antitrust exemptions beyond what current law permits, would only serve to undermine these objectives by insulating collusive activities. **Ultimately, the public could bear the brunt of these changes in the form of:**

- **Higher Prices.** Antitrust laws prevent price-fixing and the potential boycotting of health plans while promoting competitively priced fees that lower health costs. Last year, FTC Chair Janet D. Steiger testified that "experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and thwart cost reductions."
- **Reduced Quality and Choice.** If physicians are allowed to engage in otherwise prohibited collaborations, they could act to restrict the type and categories of providers available to patients. In addition, sanctioning limited competition among certain providers could reduce their incentive to improve quality of care and service.
- **Less Innovation.** Existing antitrust law provides adequate flexibility for physicians, hospitals and professional groups to work together to organize new networks and other provider delivery systems. More importantly, they help promote innovation by encouraging providers to distinguish themselves in ways that will benefit consumers—for example by competing on the basis of quality as well as cost. New antitrust exemptions would simply halt the competitive incentive for innovation.

While we acknowledge that additional enforcement guidelines may be necessary as the new health system evolves, we also recognize the very real dangers inherent in moving beyond what current law has deemed to be safe. appropriate and necessary. We are thus in complete agreement that changes to existing antitrust laws are simply unnecessary and a real threat to consumer welfare.

Sincerely,

Aetna
American Association of Nurse Anesthetists
American Association of Retired Persons
American College of Nurse Midwives
American Federation of Home Health Agencies
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Speech-Language Hearing Assn
Blue Cross of California
Blue-Cross & Blue Shield Association
CIGNA Corporation
Consumer Federation of America
Consumers Union of United States
Federation of American Health Systems
Group Health Association of America

Home Health Services & Staffing Assn
Independence Blue Cross
Metlife
National Assn of Childbearing Centers
National Capital PPO
The ERISA Industry Committee
The Principal Financial Group
The Prudential
The Travelers Insurance Companies
Washington Business Group on Health
U.S. Healthcare

PREPARED STATEMENT OF JOHN H. NILES, MD

Mr. Chairman and Members of the Committee:

My name is John H. Niles, MD. I am a physician with a specialty in the field of obstetrics and until April of this year served as Chief of Staff at the Columbia Hospital for Women in Washington, DC. I am also a former President of the Medical Society of the District of Columbia and a member of the National Medical Association, the American Medical Association and the American College of Obstetricians & Gynecologists. On behalf of the Health Care Liability Alliance and myself, I am pleased to have this opportunity to testify regarding the need for effective liability reform as a necessary component of health system reform.

The Health Care Liability Alliance (HCLA) is a coalition of health care providers, insurers, health service organizations, and individuals who believe that our country's dysfunctional system for resolving health care liability disputes is a national problem that demands a national solution. The HCLA's members have come together with the common

purpose of calling for the inclusion of health care liability reform in federal health care reform legislation (HCLA Membership list is Attached as Appendix A).

As the *1994 Physician Payment Review Commission (PPRC) Annual Report to Congress* published earlier this month -- and many reports before it -- make clear, the current system for compensating patients who have been injured in the course of receiving health care services is broken and should be repaired at the national level. (The PPRC Report is attached as Appendix B.) The system is inefficient and wasteful, contributes to problems with patient access to obstetrics and other specialty services, produces unfair and inconsistent outcomes, and benefits lawyers more than it does the injured plaintiffs in a dispute. Unless changes are made in our liability laws, health care costs will continue to increase and access to health products and services will continue to be constrained unnecessarily.

Members of the HCLA believe that these changes should apply equally to all potential defendants in personal injury cases arising from the delivery of health care services. Physicians will continue to practice "defensive" medicine or be reluctant to provide treatment to patients in those areas of medicine that are plagued by lawsuits. Life-saving drugs and medical devices will be slow in emerging and cost more, or they may be completely unavailable. Health care costs will increase as managed care plans -- increasingly targeted as the "deepest pocket" of all defendants -- feel constrained to pay for unproven or experimental treatments rather than run the risk of multi-million dollar awards prompted by juror anger about greater restrictions on health care utilization.

For these reasons, the members of the HCLA believe that national health care reform will not be effective unless it includes broad-based liability reform applicable in all claims

arising from the delivery of health care services, whether the defendants are physicians, nurses, hospitals, pharmaceutical and medical device makers and distributors, managed care organizations or others. Twenty years of experience in the states has produced valuable information upon which to craft federal policy. In particular, California's Medical Injury Compensation Reform Act (MICRA), in place since 1975, has proven to be an effective model, and is the basis of the legislative package supported by all HCLA members.

DEFINING THE PROBLEM

The United States has the world's most expensive tort system. At 2.3 percent of Gross Domestic Product, U.S. tort costs are substantially higher than that of any country, according to surveys by the Tillinghast actuarial firm, and two and a half times the average of all developed countries. The U.S. tort system cost $132 billion in 1992. Between 1933 and 1991, U.S. tort costs rose by a factor of almost 400. By contrast, U.S. economic output (GNP) grew only one hundredfold over the same period. Thus, tort costs have grown almost four times faster than the U.S. economy over the past 58 years. (*Tort Cost Trends, An International Perspective*, Tillinghast 1992.)

In the District of Columbia where I practice , malpractice premiums for obstetricians have risen 550% in the last 15 years. I have paid as much as $60,000 for liability insurance, and there is no indication that the rates will decrease any time soon without comprehensive liability reform. My experience in Washington is in stark contrast to physicians in states where effective liability reform has been achieved. (A comparison of District of Columbia and California premiums is attached as Appendix C.)

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Despite the magnitude of spending, our tort system functions very poorly in meeting its objectives of compensating victims and improving safety by deterring careless or wrongful behavior. No where is this truer than in what the RAND Corporation has accurately dubbed the "high stakes" world of medical liability and product liability litigation. (*Trends in Tort Litigation: The Story behind the Statistics*, RAND R-3583-1CJ, 1987.) For many years this country has grappled with the growing inability of the civil justice system to resolve health care liability claims in a fair, timely and cost effective manner.

Health Care Liability: A Public Concern

Americans want reform and are frustrated by the failure of lawmakers in most states to take effective action. They increasingly look to the Congress for leadership.

Every recent poll has demonstrated that the American public strongly supports effective medical liability reform as a component of health system reform. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care. The Los Angeles Times found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. A 1992 survey shows that 44 percent of the public believe only about half of the plaintiffs in civil liability lawsuits have just cause to file suit. And a growing number -- now a third of the population (34 percent) -- say that the majority of civil liability lawsuits can't be justified.

Many jurors also feel lawsuits are abused. In interviews with 269 jurors in the Northeast, Valerie Hans, a professor at the University of Delaware, says she was struck by the jurors' spontaneous referrals to "frivolous lawsuits" and "litigation explosion." The

jurors' attitudes showed in their verdicts. The jurors agreed or strongly agreed with the following statements: There are too many frivolous lawsuits today (83%); people are too quick to sue (81%); and the threat of lawsuits is so prevalent today that it interferes with the development of new and useful products (57%). (See, Appendix D, for a humorous commentary on our society's litigious climate.)

The PPRC Report, the Harvard Medical Practice Study, and reports by the General Accounting Office (GAO) and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: The current tort system, without modification, is unable to resolve liability claims cost-effectively and makes a haphazard contribution to deterring negligent behavior or improving the safety of health care.

Liability Reform Objectives are Clear

There is a broad consensus about the objectives of health care liability reform:

1. **Patient Safety Should be Promoted.**

The HCLA believes that any meaningful reform of the liability system must contain meaningful patient safeguards against malpractice or harm from medical products or services. The health care community is committed to continuing efforts to reduce the incidence of injury and strongly supports reform efforts to promote patient safety and identify incompetent providers or unethical practices. Our efforts alone, however, are not enough to remedy the many harms that the current tort system perpetuates.

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2. The System's Focus Should be Compensation for Injured Patients, not Lawyers.

People injured in the course of receiving health care treatment are entitled to fair and prompt compensation. No one disputes this. Unfortunately, the current tort system has failed the patient population.

A February 1990 study by the Harvard School of Public Health of hospital admissions in 1984 shows that of the one percent of patients whose medical records indicated some negligent treatment, only 12.5% filed liability claims. Significantly, only half of those patients -- 6.25% -- received compensation from the tort liability system. *(Harvard Medical Practice Study*, Harvard School of Public Health, 1990.)

Other data show that even when patients pursue compensation, other parties to the system reap disproportionate benefits. Attorneys' fees and expenses (both plaintiff and defendant) account for 38% of total monies spent on resolving medical liability claims, according to the RAND Corporation. Ironically, while our system ostensibly is designed to compensate the injured, RAND estimates that only 43 cents of every dollar spent in medical liability or product liability litigation reaches injured patients.

Analysis of medical liability cases closed in California in 1993 indicate that the state's graduated limits on attorney contingency fees resulted in patients keeping an additional $9 million in compensation that would have otherwise gone to their attorneys. (*1993 Medical Malpractice Large Loss Trend Study*, Medical Underwriters of California, April 1994; see also, Appendix E, a 1989 Forbes article on the impact of excessive contingency fees on tort costs.)

3. **The Patient/Provider Relationship Should be Strengthened, Not Impeded.**

According to the Harvard Study, health care is completely safe for 99% of patients in hospitals. The health care liability system should be designed to target providers who engage in the one percent of cases that may involve unsafe or unethical practices. Instead, it currently creates an overall climate of fear and suspicion that impede the maintenance of trusting therapeutic relationships.

The average physician has a 37% chance of being sued at sometime in his or her career. This increases to 52% for a surgeon and 78% for an obstetrician. A compelling indicator of the current system's failure is the fact that *a physician's chance of being sued for medical liability bears little relation to whether he or she has been negligent*. The Harvard data show that 80% of the claims for medical negligence filed in New York did *not* correspond with a negligent adverse event. These findings reinforce the GAO's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement, or any payment of compensation in the plaintiff's favor (*Medical Malpractice, Characteristics of Claims Closed in 1984*, U.S. General Accounting Office, 1987). These numbers show that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence in a targeted way.

4. **The Liability Component of Health Care Costs Should Be Contained.**

All patients bear the burden of the high health care liability costs paid by potential defendants, when their costs are passed on in the form of more expensive health care services. In assessing the full extent of liability costs, several component factors should be considered.

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The first component is liability insurance premiums, which have been a significant factor contributing to the growth in patients' health care bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 15.1% between 1982 and 1989. *(The Cost of Medical Liability in the 1980s*, American Medical Association, 1992.) Estimates show that for each baby delivered in Florida, $1,119 goes toward payment of liability insurance, and average premiums paid by self-employed physicians tripled in the 1980s. The cost is especially heavy for some high-risk specialists in certain states whose premiums have exceeded $100,000 and approach as much as $200,000 annually. The estimated annual cost of liability insurance for physicians and health care facilities has been placed at more than $9 billion in 1992 and continues to grow.

A second factor is the cost attributable to "defensive medicine," the term used to describe diagnostic tests and services motivated primarily by the fear of litigation and the perceived need to build a medical record that documents a health care professional's judgment. While difficult to precisely quantify, defensive attitudes and practices are real and entirely understandable when physicians have a 38% average chance (up to 78% for obstetricians) of incurring a claim regardless of the quality of care they provide. The AMA estimates that this practice added an additional $15.1 billion to the cost of health care in 1989. Lewin-VHI estimates the combined cost of physicians' and hospitals' defensive practices to be as high as $25 billion in 1991. (*Estimating the Costs of Defensive Medicine*, Lewin-VHI, 1993.) In an April 1994 study, the Hudson Institute's Competitiveness Center reported that liability premiums and defensive medical contributed $450 per patient admitted

to a large urban hospital in Indiana, representing an average of 5.3% of the patient's health care costs. (DM McIntosh, DC Murray, *Medical Malpractice Liability, An Agenda for Reform*, Hudson Institute, 1994.)

According to the Lewin-VHI report, comprehensive medical liability reform as a component of health care delivery system reform could save an estimated $35.8 billion over the next five years by curbing premium cost and many defensive medical practices. The Lewin-VHI study predicts that tort reform savings will accrue at an accelerated rate as practice patterns begin to change.

The liability costs borne by makers of medicines and medical products contribute additional billions to the national health care bill. In 1990, $10.8 billion was paid to claimants in all health care product liability cases in the U.S. -- and that does not include associated administrative and legal defense costs.

Adding these components together, the total cost of physicians' and hospitals' liability premiums, defensive medicine, and coverage for makers of medicines and medical devices, is more that $45 billion annually.

A final cost factor that is potentially enormous, but has not yet been adequately measured, is the liability of managed care systems for their utilization review activities that restrict payment for health care services that patients demand. Recent verdicts and settlement reports suggest that payors who refuse to provide services have multi-million dollar exposure in such cases, even if the medical service demanded by the patient has not been proven effective and is clearly excluded by the terms of the managed care plan. (See *Patients' Lawyers Lead Insurers to Pay for Unproven Treatments*, New York Times, March 28, 1994,

page A1.) It is difficult to imagine any scenario in which cost containment initiatives can be successful, if the business risk in denying such benefits is a virtually unlimited jury verdict.

5. Medical Innovation Should be Encouraged, not Derailed.

The threat of liability acts to inhibit medical innovation and deprives health care professionals of certain medicines and medical devices needed for optimal patient treatment. The threat of litigation prompted seven of eight pertussis vaccine manufacturers to withdraw from the market between 1960 and 1985, even though no sound scientific study has even confirmed a cause and effect relationship between the vaccine and any adverse neurological reaction. To prevent a dangerous shortage of the vaccine, the federal government established a compensation fund financed by an increase in the cost of the vaccine. Excessive litigation costs were also the reason that the manufacturer of the morning sickness drug Bendectin withdrew its product from the market, even though there is no credible scientific evidence to this day linking it to birth defects. Patients suffer needlessly because no substitute therapy for morning sickness has been developed -- the product liability litigation risk is just too high.

6. Access to the Comprehensive Health Care Should be Promoted.

Perhaps the most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and to cease provision of certain services in various areas of the country.

Physicians and health care institutions have limited their medical practices in response to the liability climate. These restrictions on access to health care services have been

seriously felt by obstetric patients, indigent patients, and those living in rural areas. Almost one out of eight obstetrician/gynecologists (12%) has dropped obstetrical practice as a result of liability risks. (*Professional Liability and its Effects: Report of a 1990 Survey of ACOG's Membership*, American College of Obstetricians and Gynecologists, 1991.) More than a half million residents of rural counties are without any physicians who provide obstetric services. (*Health Care in Rural America*, Office of Technology Assessment, September 1990.) Nor is this phenomenon limited to rural areas. An example of this problem was presented by Senator Riegle (D-MI) while chairing a 1991 hearing on health system reform, when he indicated that his family was unable to remain with its obstetrician of choice because that physician gave up obstetrics practice. This did not happen to a citizen in a rural community. It happened to a U.S. Senator in the District of Columbia. (See also, Appendix F, a 1988 report on the impact of tort liability on physician participation in the Medicaid program prepared by the District of Columbia Medical Society; and Appendix G, a 1990 Southern Legislative Conference report detailing numerous liability related access problems in rural areas.)

I can personally verify that the high costs of liability are a significant factor in the decisions of many physicians, in the District of Columbia and across the country, to drop or retire from high risk specialty areas such as obstetrics. Unfortunately, it is often the poor or uninsured in both rural and urban areas that are most affected. After many years of advocating reform in Washington -- a city that desperately needs it -- I am convinced that the serious access problem will not be remedied without strong national leadership.

Liability concerns are increasingly creating obstacles to the availability and affordability of medical devices as well. In response to hundreds of claims filed against them, E. I. DuPont Company is restricting the sale of its Teflon product to the makers of lithium batteries used to power heart pacemakers. Even though it had no role in designing the pacemaker device or the lithium batteries, because DuPont supplies a raw material it is included in the legal chain of responsibility. By virtue of their size a supplier like DuPont may have deeper pockets, and therefore may be more vulnerable to suit, than smaller companies who actually design or produce the product. For the same reason, DuPont and other companies are also restricting the sale of raw materials to manufacturers of jaw implants, artificial blood vessels, heart valves and sutures, among others devices. (*Implant Industry is Facing Cutback by Top Suppliers*, New York Times, April 24, 1994, page A1).

Until some reasonable limits are put on the liability exposure of defendants in health care injury cases -- limits that provide fair, but not unlimited compensation for injured patients -- these access problems will not be abated.

FEDERAL LEADERSHIP IS NEEDED

Every shareholder in the medical liability system has the opportunity and the responsibility to make the system work better. The health care community is actively carrying out its responsibility to identify high-risk of injury situations and address through a variety of patient safety and loss prevention programs in virtually every medical setting. Unfortunately, we can do little to remedy the waste in our country's tort system. We hope that other participants in the system will heed the call to participate in this effort. As the federal government fashions a nationwide overhaul of the health care delivery system, it

should act to realize a viable and consistent solution to the panoply of issues raised by health care liability.

The litany of problems with the current tort system does not necessarily mean that the system must be abandoned. The HCLA believes that a fault-based system permits meritorious claims, screens out claims with no merit and lowers transaction costs can work. Reforms such as those adopted in the states of California tell us that the current system is a good candidate for reform, and that moderate reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution.

Federal Preemptive Tort Reform

Federal preemptive tort reform represents a bold approach, but the only one that could advance a nationwide solution to this complex problem.

Virtually every health system reform bill introduced to date incorporates a federal preemptive liability reform title, including the Clinton Administration's Health Security Act (S. 1757/H.R. 3600). (See Appendix H for a comparison of liability titles of major health system reform bills.) Although the President and the First Lady should be commended for including some limited liability reform concepts in S. 1757, the liability reform sections of their bill fall short of actions needed to accomplish meaningful liability reform.

In any federal preemptive scheme, states should be left with substantial power to implement additional or alternative reform programs, that are equally effective at meeting federal objectives, and to experiment with a wide variety of alternative dispute resolution approaches to injury compensation. State-based demonstration projects like those now

underway in Maine and a handful of other states to evaluate the use of clinical practice parameters/guidelines in litigation should also be helpful in evaluating whether such guidelines can reduce liability costs.

Necessary Reform Provisions supported by the HCLA.

The members of the HCLA agree that effective health care liability reform will not be achieved unless the reform provisions described below are adopted at the national level. These provisions are based on California's MICRA legislation, in place in that state since 1975. The California model ensures full and fair compensation for all actual losses, yet limits costs through various controls exerted on the "lottery" aspects of the medical liability system, notably a ceiling on non-economic damages and graduated limits on attorney contingency fees as claimants' awards rise. After nearly 20 years of experience in California, we can confidently conclude that California's limits on costs in high stakes cases have stabilized medical liability expenses overall, despite a pattern of long term growth in the frequency of liability claims in the state.

1. Apply liability reform provisions to all potential defendants in disputes arising from injuries received in the course of health care services delivery. Many liability reform titles, including the Health Security Act, apply only to malpractice actions brought against health care professional and institutional providers. Yet the manufacturers of prescription drugs and medical devices, providers of blood and tissue services or products, and managed care organizations are all at risk of lawsuit as well when a patient is injured. It should also be noted that hospitals, clinics and other institutional providers are sued not just for malpractice, but for personal injury alleged to result from their distribution of medical

devices, pharmaceutical and blood/tissue material. Addressing the liability problems in just one part of the health care sector may actually stimulate litigation in other parts which are then perceived to have "deeper pocket." This detrimentally impacts medical technology manufacturers by deterring the development of new innovative, cost effective products. For all of these reasons, the liability reform umbrella should encompass all potential defendants in claims arising from injuries experienced in the course of health care treatment.

2. $250,000 Non-Economic Damages Ceiling. Limits on non-economic damages are the single most effective reform in containing medical liability premiums, according to a September 1993 report *Impact of Legal Reforms on Medical Malpractice Costs* by the OTA. Ceilings on non-economic damages do not in any way restrain the ability of a claimant to recover medical expenses, lost wages, rehabilitation costs or any other *economic* loss suffered as the result of a health care injury. It limits only those damages awarded for pain and suffering, loss of enjoyment and other intangible items. Based on the successful experience of California's MICRA legislation, HCLA members support a $250,000 limit. By international standards, this is a generous ceiling. NO other country provides a benefit this high for non-economic damages.

3. Several Liability for Non-Economic Damages. Under the current rule in many states, a defendant that is responsible for as little as one percent of the total fault may be held financially accountable for the entire award. HCLA members agree that defendants should remain jointly liable to the plaintiff for all economic losses, but should be only individually liable for the portion of non-economic damages in fact attributable to their own acts or omissions. This compromise ensures that the plaintiff will be made whole for all out of

pocket losses, yet takes a step toward establishing fairness and accountability between defendants.

4. Attorney Contingent Fee Limitations. The contingency fee is meant to be the "poor man's key to the court house." However, the contingency fee system is not serving this function well. Most persons with small health care injury claims never get access to the civil justice system, because the contingency fee stimulates lawyers to be primarily interested in the "big ticket" cases. The system would be improved if the attorney contingency fee were calculated with some "relative value," similar to what the Medicare system now imposes with respect to physician fees.

All of the major health system reform proposals limit the amount an attorney can recover as part of a malpractice award. However, HCLA members cannot support the Health Security Act's contingency fee section which limits the attorney fees to a flat one third of the award, merely preserving the *status quo*. HCLA supports California's contingent fee limit schedule: 40% of the first $50,000, 33 and 1/3% of the next $50,000, 25% of the next $500,000, and 15% of any amount by which the recovery exceeds $600,000.

5. Collateral Source Payments. This reform would permit any defendant to introduce evidence of any reimbursement received or due to be received by a claimant from health or disability insurers or others for losses resulting from an injury. Claimants are permitted to provide evidence of amounts paid to secure the collateral source benefit. Providers of collateral source benefits would not be allowed to subrogate. The Health Security Act's collateral source provision would actually *offset* the award by the amount of collateral source payments received by the claimant. HCLA members believe that the Health

Security Act's approach is not as effective as our proposal to inform the jury of such collateral source payments prior to their deliberations.

6. Future Damage Awards. Future damage awards over $50,000 should be paid periodically. The Health Security Act incorporates a periodic payment reform provision, but fails to establish a monetary threshold at which it would begin to apply.

7. Statute of Limitations. A uniform statute of limitations should be enacted that (i) establishes a standard rule that claims must be filed within one year from the date an injury is *discovered*, but (ii) provides an outside limit of three years from the date the injury *occurred*. Exceptions to these general rules allowing extra time should be made (iii) for children under age six who may not be able to communicate the existence of an injury, and (iv) in the instance where a foreign body with no therapeutic purpose is left in a claimant's body and not discovered for many years.

HCLA Comments on the Health Security Act

The Health Security Act contains a number of additional reform concepts that may or may not be effective. We offer the following comments:

1. Alternative Dispute Resolution (ADR). The ADR section of the Health Security Act is expressly non-binding, presumably in deference to the cherished right of access to a jury trial. Yet, the central objective of ADR is to divert cases from litigation. This tension can only be addressed by giving parties to a health care injury dispute some incentive to voluntarily settle with the ADR decision and not pursue litigation. Two approaches should be implemented. First, the ADR decision must be admissible as evidence in court. The jury should be informed that the dispute already has been through some

investigation or process and gives them the benefit of that process for their deliberation. Second, adopt a fee-shifting rule, whereby a claimant or defendant who rejects the ADR decision and goes forward is made responsible for the professional fees of the opposing parties if a result better than the ADR decision is not achieved. Finally, existing ADR provisions enacted by the states should not be preempted by federal law.

Many HCLA members believe that federal leadership in this area is best exercised by encouraging state or federal demonstration projects utilizing various ADR models. Because so little is clear presently as to the effectiveness of ADR, it may be appropriate to encourage state "laboratories" to try and evaluate different ADR approaches.

2. Practice Guidelines. The Health Security Act would establish a pilot program to encourage the use of clinical practice guidelines for the purpose of expediting the resolution of claims arising from care delivered in accordance with such guidelines. The HCLA would not oppose such demonstration projects, *so long as they require that practice guidelines be used exclusively as an affirmative defense by defendants in liability cases.* This approach is consistent with demonstration projects already underway in Maine and other states.

3. Certificate of Merit. Non-meritorious suits will be discouraged if plaintiffs are required to have a qualified expert submit an affidavit stating that there is a likely breach in the standard of care. In the Health Security Act, the plaintiff's claim must be supported by a qualified expert. The Act should be strengthened by requiring a separate affidavit for each defendant and a penalty for experts who file affidavits in bad faith.

4. Enterprise Liability Demonstration Project. The Health Security Act's "enterprise liability" proposal would immunize physicians, nurses and other individual health care providers from responsibility for their actions and shift liability exposure to the health services "plan." This would only shift the associated liability costs, and instead of reducing them, could lead to higher losses because of the "deep pocket" theory. The HCLA adamantly opposes the authorization or expenditure of federal funds to encourage *mandatory* enterprise liability.

HCLA Comments on the Chafee/Thomas Bill (S. 1770/H.R. 3704)

The Health Equity and Access Reform Today Act (S. 1770) introduced by Sen. John Chafee (R-RI), contains the most comprehensive health care liability reform title of any of the federal health system reform proposals, incorporating most elements of the HCLA list of necessary provisions with some variations. The members of the HCLA commend Senator Chafee and the other members of this Committee who have cosponsored S. 1770, including Senators Dole, Hatch, Danforth, Grassley, Durenberger, and Boren for their leadership on this important element of health system reform.

Patient Safety/Risk Management

Providing medical care today involves a complex system of persons and technology, each individual and component of which is necessary to bring about the safe and effective delivery of care to the patient. All of our activities aim at the common goal of improving patient health and preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented.

Legislation designed to enhance patient safety must occupy a central role in medical liability reform. The members of the HCLA support a number of bills introduced in the 103rd Congress would implement this approach, such as S. 1533/H.R. 3080, the "Affordable Health Care Now Act," introduced by Sen. Trent Lott (R-MS) and Rep. Robert H. Michel (R-IL). The HCLA supports the dedication of health care professional licensing fees to increase the effectiveness of state medical disciplinary boards. We also support the ability of states to enter into contracts with local professional societies to assist in investigating consumer complaints, which have the potential to significantly enhance the resources of licensing and disciplinary boards.

HCLA members remain committed to reducing the incidence of patient injury. In this context, we support required risk management training for health professionals and are proceeding with aggressive endeavors to restrict the ability of unethical physicians to practice medicine.

CONCLUSION

Mr. Chairman, our liability system needs to be fixed to meet the needs of the injured patients who deserve to be fairly compensated, the health care sector, which is willing to assume their fair share of the responsibility for avoidable patient injury, and society, which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

I appreciate the opportunity to appear before the Committee and would be pleased to respond to questions.

Appendix A

HEATH CARE LIABILITY ALLIANCE
MEMBER LIST (Companies & Associations)

American Academy of Dermatology
American Academy of Ophthalmology
American Home Products Corporation
American Hospital Association
American Medical Association
AMA/Specialty Society Medical Liability Project
American Society of Healthcare Risk Managers
Biotechnology Industry Organization
Californians Allied for Patient Protection
Council of Community Blood Centers
The Doctors' Company
Health Insurance Association of America
Health Industry Manufacturers Association
Medical Protective Company
Medical Mutual Liability Insurance Society of Maryland
MEDMARC Insurance Company
MMI Companies, Inc.
National Association of Manufacturers
National Council of Community Hospitals
Pharmaceutical Research & Manufacturers of America
Physician Insurers Association of America
Physician Insurance Company of Michigan

APPENDIXES B–G WERE RETAINED IN THE COMMITTEE FILES.

PREPARED STATEMENT OF ALPHONSO O'NEIL-WHITE

Good morning Mr. Chairman. My name is Alphonso O'Neil-White, and I am the Vice President and General Counsel of Group Health Association of America (GHAA). GHAA is the national association of health maintenance organizations (HMOs) that represents 350 HMOs and whose 33 million members account for about 75 percent of total HMO enrollment nationwide. On behalf of our members and their enrollees, we appreciate your invitation to testify today.

COMPETITION IS CRITICAL TO HEALTH CARE REFORM

The HMO industry has been on the cutting edge of health care reform for more than 50 years. HMOs and other managed care plans offer comprehensive services to enrolled members on a prepaid, rather than on a fee-for-service basis.

HMOs are care systems that deliver that care through highly qualified health care professionals. Their primary goals are keeping their members well and providing first rate health care. Consumers consistently give HMOs positive reviews, which are reflected in high enrollment renewal rates. In fact, HMO enrollment has quadrupled during the past decade alone based almost entirely on consumer choice. Today, *roughly one out of every five Americans who have health insurance are enrolled in HMOs*, and GHAA estimates that HMO enrollment will exceed 50 million by the end of 1994. The vast majority of these HMO members selected their plans in an environment of choice -- they chose to be our members.

HMOs organize the delivery of comprehensive health care services in a way that makes a great deal of sense to many Americans. The benefit packages we offer tend to be significantly broader and more complete than those offered by indemnity insurers. Out-of-pocket costs are invariably lower. The collective experience of the managed care industry is a substantial part of the blueprint for many of the health care reform bills currently under consideration in Congress.

The topic of this hearing today is important to consumers, our industry, and to the future of health care reform. The basic purpose of the antitrust laws and antitrust enforcement in the health care industry is to promote and preserve competition, not to protect competitors. The antitrust laws and antitrust enforcement have played a historic and special role in the development of managed care as an alternative to fee-for-service medicine for consumers. We agree with Assistant Attorney General Bingaman's statement in her recent letter to Senator Metzenbaum that some of the proposed legislative provisions we are discussing here may protect anticompetitive conduct that significantly harms consumers.[1]

Antitrust enforcement was directly responsible for enabling the first HMO-type plan to form more than 50 years ago. In 1941, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early

HMO-type plan here in Washington, D.C.[2] In that case, the associations initiated disciplinary actions against Group Health Association staff physicians, imposed sanctions against doctors who consulted with Group Health Association physicians, and took various actions against hospitals that permitted Group Health Association doctors to practice at them -- all in an effort to prevent GHA from providing an alternative to fee-for-service practice. Unfortunately, a great deal of similar activity still occurs today.

Competition has enabled managed care plans and other new forms of health care delivery systems to provide all consumers with high-quality care through alternatives to traditional fee-for-service practice. Competition between health plans, for instance, has encouraged innovation, enhanced quality, and increased efficiency in health care delivery. Similarly, greater use of selective contracting and competitive bidding generates efficiencies and improves quality, as providers vie to demonstrate the value and dependability of their services.

Today's health care marketplace demonstrates that existing antitrust laws promote procompetitive collaboration by providers. For example, a recently released study of the American Medical Association reports that 33% of physicians are involved in medical group practices, compared with 18% in the 1960s.[3] Joint ventures among hospitals to purchase, operate or market high-technology medical equipment have never been challenged by federal enforcement agencies. Nor have the agencies challenged joint purchasing arrangements among hospitals for services such as laundry and data processing.

In addition, most hospital mergers are procompetitive or competitively neutral, a fact demonstrated by the very few challenges to the hundreds of hospital mergers that have occurred over the past decade. The Department of Health and Human Services reached the same conclusion after a three year study to determine if the antitrust laws were "chilling" hospital mergers. The study concluded that (1) there was no empirical evidence to support this assertion; (2) the enforcement agencies had made and are continuing to make a significant effort to educate the health care industry about their enforcement policies; (3) antitrust enforcement policies do not conflict with HHS's policies; and (4) it is not necessary or appropriate on the basis of current enforcement policies to support legislation that would exempt hospital mergers from scrutiny under the antitrust laws.[4]

No amount of structural reform in the health care industry will succeed if providers are organized into tightly knit cartels that reduce output, increase prices, stifle innovation or restrict entry. Sound antitrust enforcement is the best mechanism for preventing price fixing, boycotts, market allocation schemes and anticompetitive mergers or joint ventures that can lead to higher prices for consumers or exclude competitors from a dynamic and rapidly changing marketplace. Thus, antitrust enforcement is essential to achieve many of the fundamental goals of health care reform.

Unfortunately, legislation being considered by Congress would protect some of these types of anticompetitive activity and threaten the viability of HMOs and other alternatives to

fee-for-service medicine. GHAA is particularly troubled by legislative proposals that create broad antitrust exemptions that go well beyond existing antitrust law. The wholesale exemptions it establishes are completely unjustified.

The fact is the existing antitrust laws have benefited health care consumers by removing obstacles to the formation and expansion of HMOs as an alternative to fee-for-service medicine. For example, challenges have been brought against professional society ethical rules and "self-regulation" that prohibited contracting with managed care plans,[5] denials of hospital privileges to doctors affiliated with HMOs,[6] restraints by dominant fee-for-service payors on physicians affiliating with HMOs,[7] and combinations among providers to force higher reimbursements.[8] The enforcement agencies have also challenged conspiracies to obstruct utilization review programs,[9] and boycotts and other conspiracies to maintain prices or force increases in reimbursements.[10]

SOUND ANTITRUST ENFORCEMENT WILL HELP RURAL AMERICANS

Antitrust enforcement has played a significant role in keeping markets open to HMOs by stopping conspiracies to boycott or price fix, or by preventing the unlawful use of market power by provider groups to exclude HMOs from health care markets. We expect antitrust enforcement to continue to play a critical role as HMOs enter new communities. This will be particularly true in rural settings, where HMOs face many difficult challenges because rural Americans often live far away from providers and major medical centers. Rural populations are generally older and have lower incomes than their urban counterparts; their demand for medical services is high while access to providers is more limited.

HMO providers, however, have treated the challenges in rural America as opportunities rather than obstacles. In 1990, 301 HMOs served both urban and rural counties and 15 more served only rural counties. Some HMOs are expanding into these areas by using a "hub and spoke" approach, establishing their own clinics or contracting with independent physicians and hospitals in small communities so that members can obtain primary and secondary care from local providers. Specialized care and a wider range of physicians and therapists are available in the "hub" location. Other established HMOs have provided the start-up capital to finance new clinics, and have recruited providers to staff the clinics. Often, HMOs contract with visiting specialists or use staff from other facilities to provide back-up services for local physicians. Some examples of HMOs that successfully serve rural areas include:

"Heart of America" HMO in Rugby, North Dakota is in an area surrounded by farms of 6,000 to 8,000 acres where many families live miles away from their nearest neighbors. The region's reliance on farming, ranching and small business is reflected in the fact that almost half of Heart of America's 3,500 members enroll as individuals. Heart of America provides health services through a contract with Rugby's Johnson Clinic, a facility that operates four satellite clinics throughout the

area. To meet the health care needs of its members without hiring excess staff, the HMO uses a wide array of medical providers: physician assistants offer many primary care services; internists and a surgeon serve on staff; University of North Dakota medical students do rotations at the facility; and Heart of America contracts with specialists on a part-time basis.

"Lovelace Health Systems" is based in Albuquerque, New Mexico but it is expanding into rural areas of the state. This 142,000 member HMO has established a 24-hour, toll-free "hotline" that is available statewide. Each day about 200 callers speak with registered nurses who provide health care advice, information about community services, and direct tie-ins to state police and emergency response services. All Lovelace providers are linked by a common data base that makes patient information available at all sites, and on-line transmission of electrocardiograms and X-rays make it possible for specialists to interpret test results for rural primary care physicians. Lovelace also has a rural "immunization van," a cooperative project of the HMO, the state health department, and New Mexico's first lady. The van visits schools and churches in more than 20 small communities to provide immunizations in areas where there are no health care facilities.

"Healthsource Maine", a federally qualified HMO owned and operated by Healthsource, Inc., is based in Freeport, Maine. Healthsource Maine enrolls 53,500 members and serves the entire state of Maine. From 1988-1993, Healthsource Maine was involved in an alliance with the Robert Wood Johnson Foundation and the State of Maine in the MaineCare Demonstration Project, a public/private collaborative model to extend health insurance coverage to uninsured small businesses and the self-employed in rural Maine. Sponsored and administered by the Department of Health Services, MaineCare was a successful four-year pilot program offering comprehensive coverage through a contractual arrangement with Healthsource Maine. Through a combination of premium subsidies, careful benefit design, active utilization review and sophisticated pricing arrangements with providers, MaineCare succeeded in providing quality, appropriate care, and containing health care costs. MaineCare appealed to the targeted population through cooperation of employees, employers, hospitals, physicians and state government.

These and many other innovations in rural health care delivery have been implemented within the framework of current antitrust laws. In other words, cost-effective, efficient and procompetitive arrangements are occurring.

GHAA recognizes the health care needs of rural America for new services delivery systems, new providers, and new investment. You will note, however, that for these efforts to be successful, it is necessary to bring together many types of non-physician providers. Collusion by competitors works to freeze in place the status quo and often prevents new entrants to the market -- an outcome no one desires.

For example, over the past decades, there have been many efforts by provider groups to prevent non-allied providers such as nurse-midwives from participating in various health care delivery systems. Rural communities need to both expand their current effective utilization of non-physician providers, and attract and retain greater numbers of physicians.

Sound antitrust enforcement has broken down many of these barriers. The future success of these efforts, however, will be undermined if anticompetitive activities among health care providers are allowed to obstruct the ability of HMOs and other managed care plans to contract selectively with providers, or to hinder plans' cost containment efforts and quality assurance objectives.

HEALTH CARE POLICY STATEMENTS

In the past, GHAA has supported the enforcement agencies' efforts to clarify their enforcement policies and intentions. This need for knowledge and greater understanding has been particularly important for our rural members who often cannot achieve efficiencies that their urban counterparts enjoy without mergers or joint ventures, but may be uncertain about activities that are permissible under current law. Thus, we were pleased when the Department of Justice and Federal Trade Commission jointly announced their antitrust health care policy statements last September,[11] which, along with their many public speeches and statements, have given our members and, we believe, all providers, a clearer understanding of current enforcement policies and the kinds of activities they can safely undertake.

From our perspective, the Policy Statements are unusual for at least three reasons. First, they are industry specific, offering health care providers guidance tailored to their unique circumstances and concerns. Second, they create "safety zones" that assure providers that they will not be prosecuted for a wide range of activities, absent "extraordinary circumstances." This is particularly beneficial to rural providers who might otherwise be hesitant to engage in joint ventures that produce efficiencies or new services because of their uncertainty about the antitrust laws. For example, the hospital merger safety zone is specifically targeted to small, rural hospitals that are unlikely to achieve the cost-saving efficiencies that larger hospitals enjoy without merging.

Third, the Policy Statements for the first time commit the enforcement agencies to respond to requests from the health care community for business reviews or advisory opinions on prospective transactions in 90 days regarding any matter addressed in the Policy Statements, except requests relating to hospital mergers that are outside the safety zones. Thus, even if providers remain uncertain about whether their proposed activities fall within the safety zones, they are guaranteed an answer from the agencies in less than three months.

These Policy Statements are also important for another reason. They not only help remove enforcement uncertainty, but they have opened an important dialogue with the industry that must continue. This dialogue and the enforcement agencies' commitment to

issue additional policy statements when needed will enhance the responsiveness of all concerned to the realities of a changing marketplace.

LEGISLATIVE EXEMPTIONS

GHAA opposes any policy or legislation that would make it harder to challenge anticompetitive combinations or agreements among local health care providers, whether organized informally or through cartels, joint ventures, networks, associations or mergers. I S. 1658 and similar provisions in S. 1770 are enacted, the ability of enforcement agencies to be responsive and flexible will be seriously threatened. These bills raise precisely these possibilities; they would create broad antitrust exemptions that go far beyond existing antitrust law without any empirical data to justify the need for sanctioning such potentially anticompetitive activities. In fact, the legislation would likely undermine the consumer protections the current antitrust laws are intended to provide -- protections that have also enabled the integrated health care delivery systems to flourish as an innovative, cost-effective alternative to fee-for-service medicine.

In short, GHAA opposes any legislation of this type because (a) the antitrust laws have not impeded procompetitive mergers or joint ventures; (b) the legislative provisions would sanction anticompetitive activities; (c) statutory exemptions are inflexible and unresponsive to changes in a rapidly changing health care marketplace; and (d) some exemptions would require expensive, regulatory bureaucracies to implement them. The Health Care Policy Statements issued by the enforcement agencies do not have these problems. Our analysis of the legislative provisions in S. 1658 and S. 1770 illustrates these concerns.[12]

PHYSICIAN NETWORK IMMUNITY WOULD INCLUDE ALL PROVIDERS

Both the proposed legislation and the Health Care Policy Statements would exempt physician networks of 20% or less of the physicians in each specialty who practice in various geographical markets, but the legislation extends this immunity to all providers.[13] Significantly, the Health Care Policy Statements require joint venture participants to share substantial financial risk of profit and loss. The safe harbor in the proposed legislation, however, would cover much more than joint ventures. It would effectively immunize price-fixing among competing providers based solely on their market share without any consideration of whether the joint venture has a procompetitive purpose, would raise prices above competitive levels or would prevent the formation of other joint ventures.

The harm to consumers and managed care plans from such an exemption cannot be underestimated. In short, it is a license for 20 percent of the competitors in a market to fix prices, boycott or divide the market. Such illegal joint ventures would become common where they involved less than 20 percent of the market, and would directly impede the ability of managed care plans to contain costs and enter new markets. One could envision the

possibility of five separate cartels existing in a market to negotiate with HMOs and other payers. The impact from such anticompetitive activities would be exacerbated in small communities. HMOs would have great difficulty contracting with providers without facing boycott threats or price-fixing conspiracies.

IMMUNITY FOR "GOOD FAITH" SELF-REGULATION

S. 1770 permits a "good-faith" standard setting and enforcement by any medical self-regulatory entities such as hospital boards and medical societies, unless such activities are done for "financial gain."[14] In contrast, the Health Care Policy Statement allows only physicians to collaborate to provide data to third-party payers and set practice parameters, and specifically exclude boycott threats and fee-related information from the safety zone. The history of the health care industry is replete with examples of boycott threats by physicians who, in the guise of "standard setting" or "quality control," have attempted to coerce managed care plans into meeting their demands. When physicians and other providers have the unrestrained authority to dictate standards and engage in enforcement (disciplinary) activities, the possibility of anticompetitive behavior increases substantially and innovative modes of practice such as HMOs and other models of managed care can be suppressed. Some hospitals have used peer review processes to deny privileges to competing practitioners where the denial was unrelated to quality of care issues. Thus, the proposed legislation's failure to prohibit these practices significantly expands the Health Care Policy Statement's safety zone (as well as existing law), undermining the ability of managed care providers to implement cost-saving practices.

IMMUNITY FOR SHARING PRICE INFORMATION

Both the proposed legislation[15] and the Health Care Policy Statements would exempt participation in third-party surveys on prices and employee compensation if the data is at least three months old and the results are aggregated before dissemination to shield the identity of any particular survey participant. These aggregation and age requirements standing alone are inadequate to prevent signaling or other attempts to fix prices; therefore, the Health Care Policy Statements include several other safeguards. The safety zone in the Policy Statement includes only hospitals, rather than all providers. In addition, at least five hospitals must participate, and no single hospital can contribute more than 25% of the data. This removes the possibility of two-party surveys that would reveal the other party's data, or very small samples in which the identity of the survey participants could easily be determined. These precautions are especially important to the formation of new HMOs and the expansion of existing managed care plans that depend on competition among provider groups to negotiate prices. Under the proposed legislation, with fewer safeguards and no limitations on the providers that can participate, there would be a significantly greater risk that the surveys would be used by providers to exchange current and future price and cost information. Activity that has substantial potential for raising health care costs.

IMMUNITY FOR HIGH-TECHNOLOGY JOINT VENTURES AND EXPENSIVE SERVICES

The proposed legislation would significantly expand the protection accorded these types of joint ventures to **all** providers without any evidence that such broad protection is needed or justified.[16] This is particularly true in light of the enforcement record in this area where there have been no challenges to joint ventures between hospitals. A Health Care Policy Statement has been issued dealing with high-technology joint ventures that should encourage such undertakings.

The proposed legislation also permits joint ventures for the provision of costly services in addition to equipment, but the services intended to be exempt from antitrust enforcement are undefined. This expansion is not only vague, but there is no evidence that the development of innovative or costly medical services has been impeded by the antitrust laws.

HOSPITAL MERGERS

The proposed legislation permits mergers of hospitals with fewer than *150 operational* beds,[17] while the Health Care Policy Statements place the limit at *100 licensed* beds. In addition, the inpatient census under the legislation must be less than 50%, while the Health Care Policy Statements require an average inpatient census of less than 40% over the three previous years. **An expressed intent of the Health Care Policy Statements is to permit mergers among small, rural hospitals where demonstrable efficiencies can be realized that otherwise would be impossible.** For example, if one of two rural hospitals is failing or they both have a very low patient census, cost savings from consolidating in-patient medical services in one facility and out-patient services in the other would eliminate wasteful duplication, inefficiency **and** benefit consumers.

The proposed legislation, on the other hand, substantially broadens the class of transactions covered by the exemption. The legislation would cover far more than the special problems of rural, inefficient and economically strapped facilities. The use of operational rather than licensed beds and higher census rates allowed under **the proposed legislation would significantly expand the safe harbor to exempt hospitals that could be viable without merging.** The effect of the proposed legislation would be to move toward a general exemption for hospital mergers without requiring any empirical evidence that they are justified.

IMMUNITY FOR "GOOD FAITH" NEGOTIATIONS

The proposed legislation would protect "good faith" negotiations to organize or carry out any of the activities in the safety zones, even if the negotiations are unsuccessful.[18] The Health Care Policy Statements have no corresponding exemption, for good reasons. First, there is no evidence that it is needed. Parties have been able to form legitimate,

procompetitive joint ventures without this provision and without scrutiny from the enforcement agencies. In addition, it raises the serious likelihood of sanctioning sham negotiations that are characterized as unsuccessful efforts to establish legitimate joint ventures, but in fact are little more than collusion to set prices or divide markets. The potential negative impact on managed care is evident. The proposed legislation contains no notification requirements, so the ability of the enforcement agencies to monitor such "negotiations" would be severely inhibited. Thus, parties either could engage in "negotiations" privately, or, if questioned by the enforcement agencies, rely on the "good faith" safe harbor to protect themselves from scrutiny or investigation. The effect would be to create an exemption that encourages collusion.

ADDITIONAL SAFE HARBORS MANDATED

The proposed legislation requires the Attorney General to solicit public proposals for additional safe harbors, determine whether they meet the criteria specified in the bill, and explain her decisions to Congress - all within 180 days of enactment.[19] Within the following 180 days - merely one year after enactment - the proposed legislation states that the Attorney General "shall" promulgate additional safe harbors. If additional safe harbors are justified in the health care industry on the basis of experience and economic analysis, however, **the enforcement agencies already have the discretion they need to issue additional Health Care Policy Statements or to amend the current Policy Statements to meet the legitimate needs of providers and consumers.**

REQUIRED CERTIFICATION OF COMPLEX TRANSACTIONS

The proposed legislation would confer antitrust immunity on providers who obtain a certificate of review from the Attorney General.[20] A certificate would have to be granted if the proposed activities meet the criteria specified in the legislation and the benefits of the venture outweigh its disadvantages. If the Attorney General does not make a determination *within 90 days* following receipt of an application, it would be deemed to be approved. **This "negative option scheme" would overburden the Department of Justice with an expensive, bureaucratic process that would divert its limited enforcement resources.** As a result, the Attorney General could be forced to certify complex transactions and activities without adequate consideration of their economic effects to the detriment of managed care plans and consumers. Further, large, highly complex hospital mergers or other transactions that generally take more than 90 days to evaluate could effectively become immune from antitrust scrutiny because the analysis for such large transactions would be impossible to complete under the unduly restrictive time constraints.

ELIMINATION OF PRIVATE ANTITRUST ACTIONS

Under the proposed legislation, joint ventures that are disclosed to the Attorney General would be subject only to Rule of Reason analysis and actual, rather than treble damages if their activities are later challenged.[21] In addition, the losing party in a civil

action would bear both the cost of the suit and attorneys fees. This special treatment is extended to provider joint ventures that file *no notification at all* if their members share substantial financial risk and limit the proportion of providers, or of the specialists in the relevant market, to 50 percent for nonexclusive and 35 percent for exclusive arrangements.[22]

While not creating an outright exemption, this "special treatment" provision effectively immunizes the health care industry from private antitrust actions. By raisin the standard of proof (which is accomplished by shielding conduct such as price fixing from any possibility of per se condemnation); limiting available damages, and shifting costs and attorneys fees to the losing party, significant barriers to bringing a private cause of action are created. HMOs and other entities representing consumers' interests (which are the most likely to be victims of anticompetitive conduct) would be severely inhibited from exercising their rights under Section 4 of the Clayton Act[23] to pursue civil actions as "private attorneys general" to redress antitrust violations, which Congress originally intended. This is exacerbated by the non-notification provisions which would enable joint ventures to qualify for special treatment without the advance knowledge o the enforcement agencies. This "special treatment" will reduce the ability of managed care plans to protect consumers and to prevent provider joint ventures from engaging in illegal boycott threats, price fixing, and other anticompetitive practices when negotiating with providers.

FEE SCHEDULE NEGOTIATION

GHAA also opposes provisions like those in S. 1757 (Health Security Act) that woul permit competing providers to collectively negotiate fee-for-service fee schedules with health alliances.[24] The proposed legislation would confer antitrust immunity on providers who collectively negotiate a fee-for-service schedule with an alliance even if they are not part of an integrated joint venture.

Although the immunity does not apply to negotiations with health plans or networks, the proposed immunity could have important anticompetitive implications. First, virtually no other group of competing sellers can freely operate as a cartel under similar circumstances. Second, the natural effect of this legalized collusion will be a rise in fee-for-service prices with subsequent increased costs to consumers for whom HMOs or PPOs are not adequate alternatives. Third, but perhaps most important, the collusive activity sanctioned in the newly regulated fee-for-service market poses a significant threat of spilling over into providers' negotiations with other plans, thereby increasing providers' prices to those plans and to all consumers.

CONCLUSION

Vigorous enforcement of antitrust laws is crucial to preserve and ensure competition in the health care marketplace. Competition promotes cost containment, consumer choice and

the expansion of managed care and other innovative approaches to health care delivery that benefit consumers. There is no substantive reason why competition cannot continue to serve that role in a reformed health care system. Competition has always encouraged innovation, which is at the heart of health care reform. The antitrust laws are uniquely suited to promote these goals while preventing newly created organizations from being exploited as vehicles for collusive or exclusionary activity that is harmful to consumers.

Most of the proposed antitrust legislation, on the other hand, undercuts the protections of current law and enforcement policies without any empirical evidence to demonstrate that they have chilled or prevented procompetitive collaborations.

Finally, we urge this Committee to consider the essential role of the antitrust laws in the history of managed care, and to recognize that the future of similar innovations in health care delivery in urban and rural America will depend, in part, on the continued role of sound antitrust enforcement.

GHAA wishes to thank the Committee and the Chairman for this opportunity to present its views.

* * * *

1. See, Letter from Anne K. Bingaman, Assistant Attorney General Antitrust Division to the Honorable Howard W. Metzenbaum, Chairman, Subcommittee on Antitrust, Monopolies and Business Rights, Committee on the Judiciary, April 14, 1994.

2. American Medical Association v. United States, 317 U.S. 519 (1943).

3. "Physicians in Medical Groups: A Comparative Analysis - 1993 American Medical Association (1993).

4. "Report of the Secretary's Task Force on Hospital Mergers," Department of Health and Human Services (January 1993).

5. See American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); American Medical Association v. United States, 317 U.S. 519 (1943); American Society of Anesthesiologists, 93 F.T.C. 101 (1979).

6. See Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital, 110 F.T.C. 476 (1988). See also Medical Staff of Holy Cross Hospital, No. C-3345 (consent order of Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991).

7. Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); Blue Cross of Washington and Alaska v. Kitsap Physicians Service, 1982-1 Trade Cas. (CCH) ¶ 64,950 (W.D. Wash. 1981).

8. Association of Independent Dentists, 100 f.T.C. 518 (1982); Michigan State Medical Society, 101 F.T.C. 191 (1983); United States v. Massachusetts Allergy Society, 199201 Trade Cases (CCH ¶ 69,846 (E.d. Mass. 1992); United States v. Alston, 974 F.2d 1206 (9th Cir. 1992).

9. See Indiana Federation of Dentists v. FTC, 476 U.S. 447 (1986).

10. See e.g., American Medical International, 104 F.T.C. 177 (1984); Hospital Corporation of America, 106 F.T.C. 455 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 103 (1987).

11. Statements of Antitrust Enforcement Policy in The Health Care Area, U.S. Department of Justice and the Federal Trade Commission (September 15, 1993).

12. The Department of Justice has stated that it opposes the statutory immunities that would be created by S. 1658 and H.R.

3486. See, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division to the Honorable Howard W. Metzenbaum, Chairman, Subcommittee on Antitrust, Monopolies and Business Rights, Committee on the Judiciary, April 14, 1994. H.R. 3486 contains substantially the same provisions as S. 1658 and S. 1770.

13. S. 1770, 103rd Cong., 1st Sess. § 4202(1)(1993); S. 1658, 103rd Cong., 1st Sess. § 3(1).

14. S. 1770 § 4202(2); S. 1658 § 3(2).

15. S. 1770 §4202(3); S. 1658 § 3(3).

16. S. 1770 § 4202(4); S. 1658 § 3(4).

17. S. 1770 § 4202(5); S. 1658 § 3(5).

18. S. 1770 § 4202(7); S 1658 § 3(7).

19. S. 1770 § 4203; S. 1658 § 4.

20. S. 1770 § 4204; S. 1658 § 5.

21. S. 1770 § 4205; S. 1658 § 6.

22. H.R. 3486 deems either ventures below these size limits or ventures wherein providers share risks to have notified the agencies. S. 1658 and S. 1770 impose both size limits and risk sharing before ventures will be deemed to have notified the agencies.

23. 15 U.S.C. § 15 (West Supp. 1994).

24. Health Security Act, § 1322(C).

SOUNDING BOARD

MEDICAL PRACTICE UNDER THE CLINTON REFORMS — AVOIDING DOMINATION BY BUSINESS

THE Clinton proposal for health care reform is based on managed competition, as are the alternatives offered by Republicans in the Senate and by a bipartisan group in the House of Representatives. So the odds are good that managed competition will be part of the final health reform legislation, whatever changes Congress may decide to make in the rest of the Clinton proposal.

Managed competition, as almost everyone knows by now, means regulated competition among managed-care plans. Under the Clinton proposal medical care would be delivered by managed-care entities called "health plans," which would provide a uniform package of medical benefits through organized groups or networks of physicians on a prepaid, capitated basis. These plans would have to be approved by purchasing alliances in each state or region and, under regulations set by the alliances, would compete for members on the basis of price and quality. Depending on their organization, the plans would compensate physicians by salary, capitation, or fees for service. To ensure freedom of choice, each alliance would be required to approve at least three plans, one of which would permit its members to have a free choice of physicians paid on a fee-for-service basis. In the price-competitive market envisioned by the President's proposal, however, group- and staff-model health maintenance organizations (HMOs) would probably be the lowest bidders, and independent practice associations (IPAs) the next lowest. These plans use primary care physicians as gatekeepers. Plans without gatekeepers, in which all physicians are paid a fee for service, would be the most expensive. Since consumers would have to share the costs with the government or their employers, the less expensive plans would almost certainly dominate the market — which, of course, is how the advocates of managed competition believe health care costs should be controlled.

HMOs and other types of plans that provide tightly managed care based on gatekeeping have been growing rapidly during the past decade, and the legislation likely to emerge from the Congress next year will undoubtedly accelerate this trend. An era dominated by the independent solo practice of medicine is ending. Within another decade or so, the majority of practicing physicians will belong to organized groups of providers who will be working on salary for health plans or contracting with them for delivery of services on a fee-for-service or capitation basis.

Who will own these health plans? This is a crucial question, and it has not yet been sufficiently addressed by the Clinton administration or by the public and the medical profession. Unless preventive measures are taken, all present signs indicate that most plans will be owned by insurance companies or other health care businesses. Under the Clinton proposal, hundreds of billions of dollars will be dispensed through the alliances to buy prepaid comprehensive care from health plans. To capture that vast revenue, health insurance companies are changing themselves into comprehensive health care companies. New businesses are also entering the field, eager for a share of what promises to be a huge and profitable market. To build networks of providers, all these companies are now aggressively recruiting physicians through the acquisition of solo or group practices, as well as HMOs. Many community hospitals are doing the same thing.

Serious problems arise when third parties own or manage physicians' practices. In general, but particularly when they are investors, third-party owners of health plans will have a strong financial interest in spending as little on medical services as they can without displeasing their subscribers. This will mean not only constant surveillance of clinical practices by management but also frequent interference with the decisions that physicians make in individual cases — a phenomenon with which doctors working in many HMOs and IPAs today are already much too familiar. There is also the problem of inappropriate, if not unethical, incentives for physicians in practices owned by entrepreneurial third parties. Equity shares, bonuses, revenue withholding, and other kinds of economic levers are often used by

tempts to remove this deterrent to the establishment of not-for-profit plans.

How could nonprofit physician-owned plans get started? In some communities such plans could be organized by the medical staffs of voluntary hospitals, perhaps with help from the hospital administration. In other communities, state or county medical societies might take the lead. And in some areas large multispecialty group practices might constitute the nucleus of a physician-owned not-for-profit plan.

Physicians should be preparing now for a new health care system based largely on organized health plans. Those who are concerned about autonomy and professional values should think twice before entering into arrangements with investor-owned businesses and would do well to consider the advantages of physician-managed, not-for-profit plans. They should also tell their congressional representatives that the new legislation must pay careful attention to the role of physicians in the health plans. No new system can succeed unless it encourages doctors to function as trustworthy advocates for their patients, uninfluenced by the economic interests of the owners of the plans while still responsive to legitimate cost concerns.

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CMA RELEASES STUDY ON HMO PROFITS AND ADMINISTRATIVE COSTS UNVEILS LEGISLATIVE PACKAGE OF MANAGED CARE REFORMS

SACRAMENTO – The California Medical Association today released a comparative financial summary of health plans licensed in California. The financial summary outlined the profits and administrative costs of California health plans for the fiscal year 1992. (The complete study is attached.)

The CMA study shows a vast differential between health plans. Kaiser, California's largest health plan, utilizes only 4.7% of the premium and investment dollars on administrative costs, while Wellpoint Health Networks, Inc. (a subsidiary of Blue Cross of California), the second largest health plan, uses 30.9% of such revenue for administrative costs and profits.

"As health care is increasingly delivered by managed care systems it is important that consumers, policymakers and the employers (who are for the most part paying the premiums) understand the full fiscal picture of the companies they are entrusting with their care, " said Steven Thompson, CMA vice-president of government relations. "This study is the first step in analyzing how overhead and profit of HMOs and managed care plans may impact the actual delivery of health care."

"California business and consumers are under the impression that annual premium increases are the result of increased medical costs. This summary shows this not to be the case," continued Thompson.

The CMA study provides the background research for part of the CMA's legislative package of managed care reforms (See attached summary). Assembly Bill 3801 introduced this year by Assemblyman Burt Margolin, the Chairman of the Assembly's Health Committee, would limit health plan profits and administrative costs to 15% of the premium collected.

In addition to AB 3801, the CMA managed care reform package includes legislation to provide due process for consumers and providers denied services by health plans and a bill to establish a state panel to determine which experimental treatments should be covered by health plans.

The data for the CMA study was gathered from various public sources, predominantly reports filed by the plans themselves with the state Department of Corporations and the federal Securities and Exchange Commission, and annual reports produced by the plans. Also included i the CMA study is a chart providing examples of executive compensation packages gathered in conjunction with the other data.

The California Medical Association is a voluntary, professional association of physicians dedicated to the health of Californians.

Fiscal Summary:
Knox-Keene Plan Expenditures
AB 3801 (Margolin)

As the public becomes more familiar with the concept of managed care, there is increasing interest in health plan expenditures--particularly in light of recent court cases involving denial of care. The expanding volume of news articles addressing such issues as health plan mergers, restructurings or conversions, 'non-profit' vs. 'for-profit' status, and above all, whether these business decisions impact the actual delivery of health care serves to further stimulate this public interest while illustrating the pressing need for reliable data that makes sense of these new developments in the managed care industry.

In response to this data gap, the California Medical Association sought to gather as much information as possible regarding the fiscal activities of Knox-Keene plans. Thus, the data gathered for this report came from a variety of sources:

1. Health Maintenance Organization Financial Report of Affairs and Conditions, as submitted by all licensed plans to the Department of Corporations for fiscal year 1992.
2. 1992 Shareholder Proxy Statements, provided by publicly traded plans.
3. 1992 Securities and Exchange Commission's 10-K Forms, provided by publicly traded plans.
4. 1992 Annual Reports
5. The CAHMO (California Association of HMOs) 1993 Profile
6. Independent Audits
7. Conversations with Plan representatives.

All of the data presented in the following charts is for fiscal year 1992; complete data for fiscal year 1993 is not yet available. If any of the data presented is in error, the error lies with the reporting to the extent that all data used for these charts has been furnished by the plans.

The Department of Insurance does not require disability insurers (indemnity plans) to report data comparable to that which is required of Knox-Keene plans by the Knox-Keene Act, therefore it was not possible to evaluate the financial performance of disability insurers at this stage of analysis.

Tables

Table 1: "Comprehensive List of Full Service Knox-Keene Plans and Public Pre-Paid Health Plans"
Table 2: "10 Highest Medical Loss Ratios"
Table 3: "10 Lowest Medical Loss Ratios"
Table 4: "Non-Profit Plans"
Table 5: "For-Profit Plans"
Table 6: "Examples of Executive Compensation Packages"

Fiscal Summary: Knox-Keene Plan Expenditures

Full Service Knox-Keene Plans and Public Pre-Paid Health Plans

FY 1992

Health Plan	Enrollees	Tax Status Date Licensed	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Profit/ Income
Aetna Health Plans of Northern California[a]	105,118[1]	For-Profit 1978	87.6%[2]	8.0%	4.3%
Aetna Health Plans of Southern California, Inc.	239,774	For-Profit 8/06/81	82.9%	6.3%	10.8%
Aetna Health Plans of San Diego, Inc.	51,800	For-Profit 8/31/83	85.0%	14.6%	0.5%
AmeriMed Health Plan[b]	75,974	For-Profit 2/27/79	69.9%	17.9%	12.3%
Blue Cross of California[c]	378,743	Non-Profit 1/07/93	92.6%	1.9%	5.5%
WellPoint Health Networks, Inc. (subsidiary of Blue Cross)	2,162,000	For-Profit 12/92	69.2%	18.2%	12.7%
Blue Shield	1,605,303	Non-Profit 3/27/78	85.6%	12.9%	1.5%
CareAmerica Southern California, Inc.	173,586	For-Profit 12/11/85	78.2%	19.5%	2.3%
Central Valley Health Plan, Inc./ ValuCare	51,493	For-Profit 9/30/85	86.5%	10.3%	3.2%
Chinese Community Health Plan	6,470	For-Profit 7/31/87	80.6%	16.2%	3.2%
CIGNA Health Plan of Southern California	563,253	For-Profit 3/23/79	86.7%	13.0%	0.3%
Coast Health Plan/ Preferred Administrators, Inc.	2,095	Non-Profit 1/23/87	72.0%	35.4%	(7.4%)
Community Health Group	23,938	Non-Profit 8/30/85	77.5%	20.7%	1.9%
Community Health Plan	13,422	Non-Profit 12/30/85	82.4%	11.6%	6.1%
Contra Costa County Medical Services	22,904	Non-Profit 4/06/78	92.3%	8.1%	(0.4%)
FHP, Inc.	372,715	For-Profit 4/11/78	83.7%	13.1%	3.2%
Foundation Health	303,085	For-Profit 11/23/77	75.3%	16.6%	8.2%

[a] Aetna Health Plans of Northern California merged into Aetna Health Plans of Southern California, Inc. in 1993.

[b] AmeriMed Health Plan was acquired by Foundation Health in 1992.

[c] In 1992 WellPoint was part of Blue Cross of California. For the purposes of this table WellPoint has been separated from Blue Cross based o
records filed with the Securities Exchange Commission by WellPoint.

Health Plan	Enrollees	For-Profit/ Non-Profit Date Licensed	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Profit/ Income
reedom Plan, Inc.	11,490	For-Profit 12/15/87	78.3%	17.3%	4.4%
Health Net	869,474	For-Profit 3/01/91	80.8%	14.9%	4.4%
Health Plan of the Redwoods	81,620	Non-Profit 3/04/80	87.0%	8.7%	4.3%
HMO California, (formerly) Greater South Bay Health Plan	2,537	For-Profit 8/28/87	70.4%	25.5%	4.1%
nterValley Health Plan	38,292	Non-Profit 5/25/79	86.7%	11.6%	1.8%
Kaiser Foundation Health Plan, Inc.	4,706,928	Non-Profit 11/04/77	95.3%	3.1%	1.6%
Lifeguard, Inc.	116,880	Non-Profit 11/14/78	90.8%	8.0%	1.2%
Maxicare	101,308	For-Profit 11/04/77	83.3%	12.3%	4.5%
MetLife Healthcare Network of California	69,232	For-Profit 6/24/86	76.4%	18.8%	4.8%
National Health Plans	32,667	For-Profit 3/20/85	80.1%	17.4%	2.6%
Omni Health Plan	44,427	For-Profit 12/31/85	86.8%	18.1%	(4.9%)
PacifiCare of California	701,290	For-Profit 5/15/78	83.6%	11.3%	5.1%
Prudential Health Care Plan of California, Inc.	469,874	For-Profit 6/29/90	81.1%	15.3%	3.6%
Qual-Med Plans for Health	168,434	For-Profit 5/22/78	80.4%	17.1%	2.6%
Scan Health Plan	4,151	Non-Profit 11/30/84	77.0%	22.4%	0.6%
Sharp Health Plan[4]	14,500	Non-Profit 9/17/92	N/A	N/A	N/A
TakeCare of California, Inc. (formerly) Lincoln National	98,000	For-Profit 12/31/86	82.1%	12.7%	5.2%
TakeCare Health Plan, Inc.	262,000	For-Profit 10/31/88	81.1%	12.0%	6.9%
The Travelers Health Network of California, Inc.	6,402	For-Profit 9/05/85	120.9%	13.5%	(34.4%)
Universal Care	42,159	For-Profit 10/15/85	83.5%	13.9%	2.6%

[4] Because Sharp Health Plan was licensed in September 1992, it has not made financial data for that fiscal year available.

Health Plan	Enrollees	Type of Co. Date Licensed	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Profit/ Income
Watts Health Foundation, Inc., United Health Plan	84,097	Non-Profit 1/30/78	82.3%	15.6%	2.1%
Valley Health Plan/ Santa Clara Valley Medical Center	3,865	Non-Profit 9/13/85	93.2%	6.0%	0.8%
Public Pre-Paid Health Plans					
Health Plan of San Mateo	40,490	Non-Profit Operational: 12/1/87	N/A	N/A	N/A
Santa Barbara Regional Health Initiative	35,164	Non-Profit 9/01/93	90.8%	6.6%	2.6%

ources: The Health Maintenance Organization Financial Report of Affairs and Conditions, as submitted to the Department of Corporations by ensed Knox-Keene plans for fiscal year 1992; Securities and Exchange Commission 10-K Forms; Department of Corporations Alpha Report of ctive Plans; public annual reports; CAHMO 1993 Profile; independent auditor reports; Knox-Keene plan and public pre-paid health plan presentatives.

Enrollment figures for the plans in this table were taken from the following sources as listed: Department of Corporations FY1992 Annual Health aintenance Organization Financial Report of Affairs and Conditions, Report 4--Aetna Health Plans of California; Aetna Plans of San Diego, Inc.; merMed Health Plan; Blue Cross of California; Blue Shield; Care-America Southern California, Inc.; Central Valley Health Plan, Inc.; Chinese ommunity Health Plan; CIGNA Health Plan of Southern California; Coast Health Plan; Community Health Group; Community Health Plan; ontra Costa County Medical Services; Foundation Health; Freedom Plan, Inc.; Health Net; Health Plan of the Redwoods; HMO of California; ierValley Health Plan; Kaiser Foundation Health Plan, Inc.; Lifeguard, Inc.; Maxicare; MetLife Healthcare Network of California; National Health ans; Omni Health Plan; PacifiCare of California; Prudential Health Plan of California, Inc.; Qual-Med Plans for Health; Scan Health Plan; akeCare of California, Inc.; The Travelers Health Network of California, Inc.; Universal Care; Valley Health Plan; and Watts Health Foundation, Y1992 Annual Health Maintenance Organization Financial Report of Affairs and Conditions, Five Year Historical Data Form-- FHP, Inc.; FY1992 ecurities and Exchange Commission 10-K Form--WellPoint Health Networks, Inc.; Plan Representatives--Health Plan of San Mateo; Santa arbara Regional Health Initiative; and Sharp Health Plan.

Total revenue, total medical expense, total administrative expense, and total income figures for Blue Cross of California and Blue Shield were ken from their 1992 annual reports. For the remainder of the plans in the table, total revenue, total medical expense, total administrative expense, d total profit/

come figures were taken from Report 2 of Department of Corporations FY1992 Annual Health Maintenance Organization Financial Report of ffairs and Conditions.

Medicare "pass-through" revenues and expenditures have been subtracted from the total revenue of Blue Cross of California and Blue Shield here these plans act as fiscal intermediaries for purposes of Medicare administration.

AB 3801 (Margolin)

In 1976 the Legislature enacted the Knox-Keene Act, which established a regulatory framework to license prepaid health plans (HMOs). The federal government, at this time, was providing development grants to encourage the creation of not-for-profit HMO's. This incentive, plus the tradition of not-for-profit payer status, prompted significant growth in this area.

Today, there are 37 licensed Knox-Keene plans, but not all are strictly HMOs. In 1980, 84 percent of all licensed plans were not-for-profit; today, less than 35 percent are not-for-profit...and public agencies operate 4 of the 14 not-for-profit plans. Of the 23 for-profit plans operating today, 8 were initially licensed as not-for-profit plans. Six of the eight converted plans are publicly traded companies.

The original Knox-Keene Act did not envision the phenomenon of conversion or restructuring of plans to for-profit status. As the HMO industry moves increasingly toward for-profit status with a larger presence on various stock markets, it is important to understand the general implication of this trend.

With a "set" capitated premium, less, not more, utilization is the economic driver; profits accrue if less care is rendered. A substantial portion of every premium dollar is siphoned off for administration and profits.

Increasing pressure on for-profit HMOs to show an impressive bottom-line to Wall Street investors demands that legal protections be created to ensure that California consumers and business will receive the medical care their premium dollars are entrusted for. To date, lawmakers and regulators have placed few restrictions upon this multi-billion dollar industry that controls over 13 million California lives.

In 1990, AB 2833 (Margolin) was enacted, a bill which would require health insurers and health care service plans to disclose the ratio of incurred claims to earned premiums to individuals and small groups under 25. The bill was introduced because of the high administrative costs usually imposed on individual and small-group policies. It was the purpose of the bill to give small employers and individuals the ability to compare and shop for health insurance coverage. However, this law has not led to any real disclosure to consumers. Furthermore, it has not led to a decrease in administrative costs. In fact, just the opposite has occurred – carriers' administrative costs and profits have continued to grow.

Our research indicates that carrier loss-ratios range fr
69% to 95% in California. Although there has b
considerable debate over rising health care costs, very li
attention has been given to the hundreds of millions
dollars spent on profits and overhead by carriers in the pa
Recently, however, there has been some focus on this iss
For example, CALPERS' 1.1% reduction in health c
premiums for 1994 involved a review of high profits:

> *"Looking at the very 'robust' pro*
> *performance of our for-profit plans,*
> *appeared that there was room for premi*
> *concessions. In addition, corporate offi*
> *compensation levels were also reviewed a*
> *there too was room for belt tightenin*
> *CALPERS News Release,*
> *February 9, 1994.*

In addition, the Health Insurance Plan of Califor
(HIPC), the state small-employer pool, also reviews medi
loss-ratios as part of its contract negotiations with hea
plans.

We are concerned that with the two larg
purchasing pools using this data, health plans will cost-sh
to other purchasers. We believe that there should
minimum standards for administrative costs and profits.

The Knox-Keene Act already provides for
limitation of 15% on administrative costs. *Health a*
Safety Code Section 1378, Title 10, *Californ*
Administrative Code Section 1300.78. Because the Kn
Keene Act did not envision the growth of for-profit plans,
definition of "administrative costs" does not include prof
Thus, AB 3801 updates the definition of "administrat
costs" to also include profits.

AB 3801 would require plans to return 85 cents
of every premium dollar to the consumer in medical servi
Currently, the returns range from over 95 cents on the do
(Kaiser) to 69 cents on the dollar (the Blue Cross for-pr
plan). As a comparison, the Medicare Progra
administrative costs are similar to Kaiser's.

Although many plans already meet their standa
(see attached medical loss-ratio charts), many plans
oppose this bill. In describing their opposition, the
Angeles Daily News states: "In order to comply, health pl
either would have to lower premiums or increase benefi
We think the people of California could live with th
alternatives!

CMA'S 1994 MANAGED CARE REFORM LEGISLATION

SB 1348: UTILIZATION REVIEW STANDARDS

SB 1348 by Senator Dan McCorquodale (D-Modesto) is co-sponsored by the California Psychological Association and would establish minimum standards for utilization review in health plans. SB 1348 would require Knox-Keene health plans to disclose to the state, their enrollees and to providers under contract with the plan, the procedures the plan uses to authorize a particular health care service and utilization guidelines the plan uses to the determine appropriate level of care required for reimbursement purposes. SB 1348 would also require every plan to establish and maintain a system to process and resolve a grievance by a provider toward a plan.

AB 3801: LIMITATION ON PROFITS AND ADMINISTRATIVE COSTS

AB 3801 by Assemblyman Burt Margolin (D-Los Angeles) would require every Knox-Keene health care service plan and disability insurer to limit administrative costs and profits to 15 percent of the premium dollar and return 85 percent to the consumer in benefits.

AB 2165: TAX CREDITS FOR SMALL EMPLOYERS

AB 2165 by Assemblyman Bill Morrow (R-Oceanside) would provide tax credits for small employers if they provide health insurance to their employees through the Health Insurance Plan of California (the state-sponsored purchasing pool) or other voluntary health alliances. The bill is currently a "spot" bill awaiting substantive amendments.

AB 3571: EXPERIMENTAL TREATMENT PANEL

AB 3571 by Assemblyman Burt Margolin (D-Los Angeles) would require the Departments of Insurance and Corporations to jointly create a cost-benefit panel which would establish standards for disability insurers and health care service plans to use in assessing claims and requests and to consider whether particular procedures, services or drugs may be excluded from coverage because they are considered experimental or not medically necessary. The bill would also require the Department of Consumer Affairs and the State Department of Health Services to establish a scientific policy panel to advise the cost-benefit panel regarding the scientific efficacy of health procedures, services and drugs.

SB 1832: OMNIBUS MANAGED CARE REFORM BILL

SB 1832 by Senator Marian Bergeson (R-Newport Beach) includes the provisions of SB 1348 and AB 3571. In addition, SB 1832 would allow patients to select a Ob/Gyn to provide primary care, and would set response time requirements for treatment approval by health plans in medical emergencies.

ASSEMBLY RESOLUTION ON HEALTH PLAN REGULATION

Assemblyman Phil Isenberg (D-Sacramento) will introduce a resolution to request the State Auditor General to do a study of the regulation of health plans in California and the feasibility of consolidation of the regulatory structure.

FOR MORE INFORMATION CONTACT: DANIELLE WALTERS (916) 444-5532

Examples of Executive Compensation Packages

FY 1992

Plan	Position	Name	Cash Compensation[1]	Total Revenue (in millions)	% Total Revenue to Medical Expense
Foundation Health Corporation	President, CEO	Daniel D. Crowley	$4,374,973	$442.7	75.3%
CIGNA Corporation	Chairman of the Board, CEO	Wilson H. Taylor	$2,391,406	$809.0	86.7%
Health Net Management Holdings, Inc.	Chairman of the Board, President, CEO	Roger F. Greaves	$1,950,437	$1,217.1	80.8%
WellPoint Health Networks, Inc. (Subsidiary of Blue Cross)	CEO	Leonard D. Shaeffer	$1,378,799	$2,275.2	69.2%
PacifiCare of California	President, CEO	Terry Hartshorn	$1,223,747	$1,313.9	83.6%
The Travelers Corporation	Chairman of the Board, President, CEO	Edward H. Budd	$1,076,029	$9.2	120.9%
Aetna Life and Casualty Company	Chairman of the Board, President, CEO	Ronald E. Compton	$851,737	$807.1	84.1%
Qual-Med, Inc.	Chairman of the Board, President, CEO	Malik M. Hasan, M.D.	$558,578	$313.8	80.40%
FHP International Corporation	President, CEO	Westcott W. Price III	$365,000	$1,616.9	83.7%

Sources: 1992 Proxy Statement to Shareholders: Aetna Life and Casualty Company; CIGNA Corporation; FHP International Corporation; Foundation Health Corporation; Health Net Management Holdings Inc.; PacifiCare of California; Qual-Med, Inc.; 1992 Securities and Exchange Commission 10-K Form: WellPoint Health Networks, Inc.

[1] Cash compensation does not included personal income from stock options, which are usually valued at hundreds of thousands of dollars. For example, the stock options awarded to Mr. Crowley (Foundation Health Corporation) in 1992 were valued at approximately $100,000.00 (low estimate).

Fiscal Summary: Revenue-Use Plan Expenditures

For-Profit Plans

FY 1992

Health Plan	Tax Status	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Profit/ Income
Aetna Health Plans of California (Northern and Southern California)	For-Profit	84.1%	6.8%	9.1%
Aetna Health Plans of San Diego, Inc.	For-Profit	85.0%	14.6%	0.5%
AmeriMed Health Plan[a]	For-Profit	69.9%	17.9%	12.3%
WellPoint Health Networks, Inc. (subsidiary of Blue Cross)[b]	For-Profit	69.2%	18.2%	12.7%
CareAmerica Southern California, Inc.	For-Profit	78.2%	19.5%	2.3%
Central Valley Health Plan, Inc./ ValuCare	For-Profit	86.5%	10.3%	3.2%
Chinese Community Health Plan	For-Profit	80.6%	16.2%	3.2%
CIGNA Health Plan of Southern California	For-Profit	86.7%	13.0%	0.3%
FHP, Inc.	For-Profit	83.7%	13.1%	3.2%
Foundation Health	For-Profit	75.3%	16.6%	8.2%
Freedom Plan, Inc.	For-Profit	78.3%	17.3%	4.4%
Health Net	For-Profit	80.8%	14.9%	4.4%
HMO California (formerly) Greater South Bay Health Plan	For-Profit	70.4%	25.5%	4.1%
Maxicare	For-Profit	83.3%	12.3%	4.5%
MetLife Healthcare Network of California	For-Profit	76.4%	18.8%	4.8%
National Health Plans	For-Profit	80.1%	17.4%	2.6%
Omni Health Plan	For-Profit	86.8%	18.1%	(4.9%)
PacifiCare of California	For-Profit	83.6%	11.3%	5.1%
Prudential Health Care Plan of California, Inc.	For-Profit	81.1%	15.3%	3.6%
QualMed Plans for Health	For-Profit	80.4%	17.1%	2.6%
TakeCare of California, Inc. (formerly) Lincoln National	For-Profit	82.1%	12.7%	5.2%
TakeCare Health Plan, Inc.	For-Profit	81.1%	12.0%	6.9%
The Travelers Health Network of California, Inc.	For-Profit	120.9%	13.5%	(34.4%)
Universal Care	For-Profit	83.5%	13.9%	2.6%

Sources: Total revenue, total medical expense, total administrative expense, and total profit figures for WellPoint Health Networks, Inc. were taken from WellPoint's Securities and Exchange Commission 10-K Form for fiscal year 1992. For all other plans included in this chart the same information was taken from the Health Maintenance Organization Financial Report of Affairs and Conditions, as submitted to the Department of Corporations by each of the plans for fiscal year 1992.

[a] AmeriMed Health Plan was acquired by Foundation Health in 1992.

[b] In 1992 WellPoint was part of Blue Cross of California. For the Purposes of this table WellPoint has been seperated from Blue Cross based records filed with the Securities Exchange Commission by WellPoint.

Fiscal Summary: Knox-Keene Plan Expenditures
Non-Profit Plans
FY 1992

Health Plan	Tax Status	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Income
Blue Cross of California	Non-Profit	92.6%	1.9%	5.5%
Blue Shield	Non-Profit	85.6%	12.9%	1.5%
Coast Health Plan/ Preferred Administrators, Inc.	Non-Profit	72.0%	35.4%	(7.4%)
Community Health Group	Non-Profit	77.5%	20.7%	1.9%
Community Health Plan	Non-Profit	82.4%	11.6%	6.1%
Contra Costa County Medical Services	Non-Profit	92.3%	8.1%	(0.4%)
Health Plan of the Redwoods	Non-Profit	87.0%	8.7%	4.3%
InterValley Health Plan	Non-Profit	86.7%	11.6%	1.8%
Kaiser Foundation Health Plan, Inc.	Non-Profit	95.3%	3.1%	1.6%
Lifeguard, Inc.	Non-Profit	90.8%	8.0%	1.2%
Watts Health Foundation, Inc./ United Health Plan	Non-Profit	82.3%	15.6%	2.1%
Valley Health Plan/ Santa Clara Valley Medical Center	Non-Profit	93.2%	6.0%	0.8%
Health Plan of San Mateo	Non-Profit	N/A	N/A	N/A
Santa Barbara Regional Health Initiative	Non-Profit	90.8%	6.6%	2.6%

ources: Total revenue, total medical expense, total administrative expense, and total income figures for Blue Cross of California and Blue hield were taken from their 1992 annual reports. For the remainder of the plans in the table, total revenue, total medical expense, total dministrative expense, and total income figures were taken from the Health Maintenance Organization Financial Report of Affairs and onditions, as submitted to the Department of Corporations by each of the plans for fiscal year 1992.

Fiscal Summary: Knox-Keene Plan Expenditures
10 Lowest Medical Loss Ratios
FY 1992

Health Plan	Tax Status	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Profit/ Income
WellPoint Health Networks, Inc. (subsidiary of Blue Cross)[a]	For-Profit	69.2%	18.2%	12.7%
AmeriMed Health Plan[b]	For-Profit	69.9%	17.9%	12.3%
Foundation Health	For-Profit	75.3%	16.6%	8.2%
MetLife Healthcare Network of California	For-Profit	76.4%	18.8%	4.8%
Community Health Group	Non-Profit	77.5%	20.7%	1.9%
CareAmerica Southern California, Inc.	For-Profit	78.2%	19.5%	2.3%
Freedom Plan, Inc.	For-Profit	78.3%	17.3%	4.4%
National Health Plans	For-Profit	80.1%	17.4%	2.6%
Qual-Med Plans for Health	For-Profit	80.4%	17.1%	2.6%
Health Net	For-Profit	80.8%	14.9%	4.4%

Sources: Total revenue, total medical expense, total administrative expense, and total profit/ income figures for the plans in the table were taken from the Health Maintenance Organization Financial Report of Affairs and Conditions, as submitted to the Department of Corporations by each of the plans for fiscal year 1992.

[a] In 1992 WellPoint was part of Blue Cross of California. For the purposes of this table WellPoint has been separated from Blue Cross based on records filed with the Securities Exchange Commission by WellPoint.
[b] AmeriMed Health Plan was acquired by Foundation in 1992.

Fiscal Summary: Knox-Keene Plan Expenditures
10 Highest Medical Loss Ratios
FY 1992

Health Plan	Tax Status	%-Revenue Medical Care	%-Revenue Administration	%-Revenue Profit/ Income
Kaiser Foundation Health Plan, Inc.	Non-Profit	95.3%	3.1%	1.6%
Blue Cross of California	Non-Profit	92.6%	1.9%	5.5%
Contra Costa County Medical Services	Non-Profit	92.3%	8.1%	(0.4%)
Lifeguard, Inc.	Non-Profit	90.8%	8.0%	1.2%
Santa Barbara Regional Health Initiative	Non-Profit	90.8%	6.6%	2.6%
Aetna Health Plans of Northern California	For-Profit	87.6%	8.0%	4.3%
Health Plan of the Redwoods	Non-Profit	87.0%	8.7%	4.3%
Omni Health Plan	For-Profit	86.8%	18.1%	(4.9%)
CIGNA Health Plan of Southern California	For-Profit	86.7%	13.0%	0.3%
InterValley Health Plan	Non-Profit	86.7%	11.6%	1.8%

Sources: Total revenue, total medical expense, total administrative expense, and total profit/ income figures for the plans in the table were taken from the Health Maintenance Organization Financial Report of Affairs and Conditions, as submitted to the Department of Corporations by each of the plans for fiscal year 1992.

Prepared Statement of Mary Lou Steptoe

Mr. Chairman and members of the Committee: I am Mary Lou Steptoe, Acting Director of the Federal Trade Commission's Bureau of Competition. I am pleased to appear before you today to present the testimony of the Federal Trade Commission on the relationship between antitrust law enforcement and health care markets.[1]

There is intense public interest in the various health care proposals that currently are being considered by Congress. I am not in a position to discuss any particular proposal; but representing an agency that for years has been an advocate and defender of the role of competition in health care, I will discuss an element that has figured prominently in the discussions to date -- how the development of managed care and other alternative health care delivery plans relies on competition. I will also address the Commission's role in protecting competition in the health care sector of the economy through enforcement of the antitrust laws.

There are two principal points. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Commission enforcement actions have challenged anticompetitive rules that prohibited physician affiliation with health care plans, and have halted organized boycotts by some health care providers against newly developing health care arrangements.

Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care markets. Proposals for broad statutory antitrust exemptions that are now being advocated by some provider groups could frustrate the drive to contain rising health care costs. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost containment efforts.

The antitrust laws have been described by the United States Supreme Court as the "Magna Carta of our free enterprise system." These laws reflect a judgment that competition generally promotes consumer welfare and produces the best mix of quality goods and services at the lowest prices. The antitrust laws also assure business people an opportunity to offer their goods and services in the marketplace, and to have their success or failure determined by consumers' preferences, not by the abuse of market power of other competitors.

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1 This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my own, and do not necessarily represent the views of the Commission or any individual Commissioner.

The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. Rather, the Commission endeavors to keep markets competitive so that firms may offer, and consumers may choose, whatever health care options they prefer. We do not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, we try to ensure that each plan may develop and grow as it meets the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede the development of health care alternatives that consumers might elect to use.

Through sound antitrust enforcement, the FTC has helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative health care delivery systems grew as consumers were attracted by the services or lower prices these plans offered. The concepts that form the foundation for some of today's reform proposals were greatly facilitated by antitrust law enforcement.

Before developing these points in greater detail, however, let me offer a general caveat. Although the Commission firmly believes that antitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost-effective health care delivery system, antitrust cannot, and will not, alone solve the problem of controlling health care costs. The suggestion is a more modest one: that antitrust has a role to play in fostering competition in health care markets and thereby facilitating other cost containment efforts. The Federal Trade Commission can and should continue to play a significant, constructive role in this process.

I. The Contribution of Antitrust Enforcement to the Development of Health Care Plans

Understanding the role that antitrust enforcement has played during the last two decades in opening health care markets to new forms of competition requires an historical perspective. Until the late 1970's, most physicians practiced solo, fee-for-service medicine. There were few alternative arrangements. Even multi-specialty group practices were rare, and health care plans that sought to compete by signing up a limited panel of selected physicians were impeded by a variety of restrictions. Most hospitals operated in a similarly independent fashion.

The early forerunners of today's managed care arrangements met with opposition. Some physicians who associated with such plans were the targets of reprisal, facing charges of unethical

conduct, expulsion from local medical societies, and loss of hospital privileges. In 1943, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early health maintenance organization ("HMO").[2] The associations had taken disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and threatened disciplinary action against hospitals at which Group Health doctors were permitted to practice.

Notwithstanding the Supreme Court's decision, alternative health delivery systems, and physicians who associated with them, continued to face opposition to their activities. In 1975, the Commission issued an administrative complaint challenging the AMA's ethical standards. The complaint alleged that the AMA's ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or HMO, "underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the "usual" fees in the community, and entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. In 1979, the Commission held that all of these restraints violated the antitrust laws.[3]

Even after the Commission's AMA case freed physicians to affiliate with health care plans, non-traditional health care plans often continued to face boycotts by providers. While some providers join managed care plans, and many others compete against them on the merits, our experience shows that some providers have engaged in illegal concerted action to resist new forms of competition. The Commission has taken action to remedy

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2 American Medical Ass'n v. United States, 317 U.S. 519 (1943).

3 American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd per curiam by an equally divided Court, 455 U.S. 676 (1982). HMOs and other managed care plans attempt to achieve cost-effectiveness by limiting the provider panel to those known to provide the desired quality of care, giving this limited panel incentives to control costs, and in some instances exercising direct supervision over the appropriateness of the course of treatment selected. While patient choice of providers is limited once the patient has enrolled in such a plan, the existence of these plans allows the purchasers to decide whether the cost savings the plans offer are worth accepting this limitation. But prohibitions of "inadequate" fees or requirements of "reasonable" provider choice can impede the ability of these plans to compete effectively.

alleged conduct such as obstructing hospital privileges for HMO physicians[4] and boycotting a hospital that was planning to open an HMO facility.[5]

Within just the last few years, the Commission has issued a series of orders against alleged threatened boycotts by physicians to prevent local hospitals from pursuing affiliation with the Cleveland Clinic, a nationally known provider of comprehensive health care services.[6] The Clinic, which operates as a multi- specialty group medical practice, offers a predetermined "global fee" or "unit price" covering all aspects of many services, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. The Commission's orders prevent such activity from recurring.

In addition to challenging conspiracies against HMOs and other innovative arrangements for health care delivery, the Commission has enjoined a number of conspiracies to obstruct cost containment measures being implemented by more traditional health plans, such as Blue Shield plans and insurance companies. For example, in the 1970's, Blue Shield of Michigan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In Michigan State Medical Society, the Commission prohibited such joint "negotiations."[7] In FTC v. Indiana Federation of Dentists,[8] the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers. The refusal to provide the X-rays frustrated the cost containment effort by preventing the

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4 Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

5 Medical Staff of Doctors' Hospital of Prince Georges County, 110 F.T.C. 476 (1988) (consent order).

6 Diran Seropian, M.D., Dkt. No. 9248, 57 Fed. Reg. 44748 (1992) (consent order); Medical Staff of Holy Cross Hospital, C-3345, 56 Fed. Reg. 49184 (1991) (consent order); Medical Staff of Broward General Medical Center, C-3344, 56 Fed. Reg. 49184 (1991) (consent order).

7 101 F.T.C. 191, 296, 313-14 (1983).

8 476 U.S. 447 (1986).

efficient operation of utilization control mechanisms.[9] We also have obtained a consent order that required the dissolution of an allegedly "sham" venture among physicians who were not economically integrated but simply operated to conduct joint negotiations to defeat the cost reduction initiatives of third-party payors.[10]

Most recently, the Commission entered a consent order settling charges that an Illinois association of chiropractors had engaged in a price-fixing conspiracy and attempted to negotiate fees and other terms with third-party payors on behalf of its members.[11] The Commission also has recently entered several consent orders with associations of pharmacies and their members that had allegedly organized boycotts to thwart third-party-payor attempts at cost containment, by jointly threatening to withdraw as providers from the payors' prescription drug benefit programs unless the pharmacies' compensation demands were met.[12]

Commission enforcement in pharmaceutical markets has not been confined to pharmacy boycotts. The Commission issued an order preventing Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.[13] This action likely saved the Department of Veterans Affairs, one major purchaser of clozapine, $20 million a year.[14]

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9 Id. at 461.

10 Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992).

11 McLean County Chiropractic Ass'n., C-3491, 59 Fed. Reg. 22163 (Apr. 29, 1994) (consent order).

12 Baltimore Metropolitan Pharmaceutical Ass'n, Inc., D. 9262, 59 Fed. Reg. 15733 (Apr. 4, 1994) (consent order). See also, Southeast Colorado Pharmacal Ass'n, C-3410, 58 Fed. Reg. 6796 (1993) (consent order); Peterson Drug Company, No. D-9227 (1992) (Commission adopted opinion of Administrative Law Judge after appeal withdrawn); Chain Pharmacy Ass'n, No. D-9227, 56 Fed. Reg. 9223 (1991); Pharmaceutical Soc'y of Orange County, Inc., 113 F.T.C. 645 (1990) (consent orders).

13 Sandoz Pharmaceutical Corp., C-3385, 57 Fed. Reg. 36403 (1992) (consent order).

14 In a second health care tying case, the Commission prohibited the owner of certain renal dialysis clinics from using a tying arrangement to circumvent Medicare reimbursement limits on outpatient dialysis services. Gerald S. Friedman, M.D., 113 F.T.C. 625 (1990) (consent order).

Not long ago, two leading manufacturers of infant formula settled Commission charges that they had engaged in unilateral facilitating practices (signalling competitors) to eliminate competitive sole-source bidding in the federal government's Women, Infants, and Children (WIC) program in Puerto Rico. The manufacturers agreed to refrain from such actions in the future and to provide restitution in the form of 3.6 million pounds of free infant formula to the U.S. Department of Agriculture, which administers the WIC program.[15]

The antitrust enforcement actions I have just described by no means exhaust the categories of the Commission's efforts to preserve competition and thus permit the market to expand the number and variety of available health care plans. For example, the Commission has brought cases that challenged restrictions on the delivery of health care services by non- physician providers, such as nurse-midwives or podiatrists.[16] The Commission does not side with non-physicians against physicians, or vice versa, but seeks to ensure that consumers have the opportunity to choose between them. In general, antitrust enforcement seeks to ensure that physicians and non-physician professionals are able -- so far as possible -- to compete on a level playing field. The resulting expanded range of choice benefits both health care plans and individual health care consumers.

Also important to health care cost containment is the preservation of competition among institutional providers of health care services, including hospitals. Thus, the Commission's review of hospital mergers helps to maintain competitive conditions that enable consumers and health care plans to choose among competing alternatives. I also would be remiss if I did not mention some of the non-hospital merger cases brought by the Commission in the health care area. In the last few years the Commission has entered into consent orders restructuring transactions among firms producing such diverse health care products as dental amalgams, human growth hormone,

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15 FTC v. Mead Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992) (consent order); FTC v. American Home Products Corp., No. 92-1365 (D.D.C. June 11, 1992) (consent order). The Commission is also pursuing allegations of price fixing against a third manufacturer that did not agree to settle the Commission's price fixing allegations. FTC v. Abbott Laboratories, 1992-2 Trade Cas. (CCH) ¶ 69,996 (D.D.C. 1992).

16 For example, the Commission prohibited boycotts of nurse midwives (State Volunteer Mutual Ins. Co., 102 F.T.C. 1232 (1983) (consent order)) and podiatrists (North Carolina Orthopaedic Ass'n, 108 F.T.C. 116 (1986) (consent order)).

and wheelchair lifts.[17] By preventing transactions that are likely to reduce competition and lead to higher prices in a broad spectrum of health care markets, the Commission's merger enforcement contributes to the overall health care cost containment effort.

II. Antitrust Exemptions and Health Care Reform

Just as sound antitrust enforcement has contributed significantly to the growth of alternative arrangements in the health care sector, so it is likely to be an important underpinning of future reform. The Commission's experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs sometimes can be frustrated by the opposition of certain providers.

Nonetheless, there have recently been a variety of proposals to create special antitrust exemptions for collective action by hospitals and physicians. Some seek an exemption for mergers and various kinds of joint ventures. Others seek an exemption for various forms of concerted action -- in particular, collective negotiations with health care purchasers and payors. Without getting into the specifics of any proposal, I want to explain the reasons for concern about exemptions in this area.

At their core, the proposed exemptions for physicians and hospitals may be based on questionable arguments about the nature of competition in health care markets and how antitrust law applies to physicians and hospitals. One argument is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other argument is that antitrust law is not flexible enough to deal with markets, such as many health care markets, that may not resemble perfect competition. In our view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

The Commission has not simply dismissed the concerns of those who are calling for antitrust exemptions. Through discussions with some of these groups, and with others, it has become apparent that much of the impetus for antitrust exemptions is due to health care providers' uncertainty about whether

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17 Dentsply International, Inc., C-3407, 58 Fed. Reg. 6796 (1993) (consent order); American Stair-Glide Corp., C-3331, 56 Fed. Reg. 26108 (1991) (consent order); Roche Holding Ltd., 113 F.T.C. 1086 (1990) (consent order).

various collaborative activities that they may wish to undertake expose the providers to the possibility of being subject to antitrust law enforcement proceedings. This is a legitimate concern, and the FTC and the Department of Justice already have made substantial efforts to address it.

One of the most important responses to the concerns of health care providers has been the joint issuance, last September, of Statements of Antitrust Enforcement Policy in the Health Care Area. These Statements underscore the commitment of the Federal Trade Commission and the Department of Justice to clarify the agencies' enforcement intentions as to collaborative activities among health care providers. The policy statements are designed to resolve uncertainties that some have said may inhibit collaborative ventures that would lower health care costs. Much of the enforcement guidance contained in the policy statements is drawn from prior advice rendered by the agencies in a variety of forms. The statements bring together this advice, as well as some new advice, in a format that is easily accessible both to attorneys and to health care providers.

The policy statements define six "antitrust safety zones" -- relating to activities by hospitals and physicians -- within which conduct will not be challenged by the enforcement agencies, absent extraordinary circumstances. The safety zones cover small hospital mergers; hospital joint ventures involving high-technology or other expensive medical equipment; hospital participation in exchanges of price and cost information; physicians' provision of certain kinds of information to purchasers of health care services; joint purchasing arrangements among health care providers; and physician network joint ventures, such as IPAs and PPOs.

The antitrust safety zones serve to clarify what health care providers <u>can</u> do together in certain areas, with little or no antitrust risk. The safety zones do not define the outer limits of lawful collaboration in these areas. Each of the six policy statements sets forth the analysis that the federal enforcement agencies will use in evaluating conduct that falls outside the safety zone.

For those matters that are not specifically addressed in the policy statements, the Commission invites health care providers to seek its advice. The Commission has committed to respond to requests for advice on matters addressed within the policy statements (except hospital mergers outside the safety zone) within 90 days after all necessary information is received. Likewise, it has committed to respond to requests for advice on all other non-merger health care matters within 120 days of receipt of all necessary information.

One of the Bureau of Competition's most recent health care staff opinion letters was issued last November to a physician joint venture, California Managed Imaging Medical Group, Inc. ("CMI"), a radiology preferred provider group.[18] CMI proposed to establish a network of radiologists to provide diagnostic imaging review and interpretation services to third-party payors, in competition with existing broker networks.

The staff opinion letter approved operation of the proposed network based on several considerations. First, the staff concluded that CMI was a legitimate joint venture that was potentially procompetitive. Under the rule of reason, operation of CMI did not appear likely to restrict competition, because it did not appear likely that CMI would attain market power. In addition, its contracts with participating radiologists were nonexclusive. For these reasons, it did not appear that operation of CMI was likely to have the power either to foreclose entry by competing radiology networks, or to force payors to deal with CMI or its participating radiologists on terms dictated by them.

The CMI staff opinion letter is just one of many health care antitrust options offered to providers by the Commission and the Commission staff. In order to help providers to learn about prior advisory opinions that may address their concerns, the Bureau of Competition last week published a summary and index of all Commission and staff health care advisory opinions issued to date. Finally, of course, the Commission's staff is always willing to provide less formal advice on proposed conduct. At this time the Commission's staff is working with several providers to help them develop procompetitive arrangements that bear minimal antitrust risks.

Furthermore, FTC and Department of Justice staff have met recently with representatives of various provider groups to attempt to address remaining issues. This multi-faceted approach to reducing health care providers' uncertainty about antitrust risks through policy statements, safety zones, and formal and informal advisory opinions is an ongoing and dynamic process. The Commission believes that it will go a long way toward allaying providers' concerns.

A. Hospital Exemptions

Recently, Congress has considered a number of proposals for special antitrust exemptions for hospital mergers and joint ventures. Certain groups have proposed legislation that would allow hospitals, under some circumstances, to obtain antitrust immunity

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18 Letter to J. Bert Morgan from Mark J. Horoschak, Assistant Director, Bureau of Competition (November 17, 1993).

for combining their operations, or sharing medical services or equipment.

Is there a need for this type of legislation? The proponents offer two arguments. First, they contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers and joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inherent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. The available evidence fails to support their assertions.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. Let me put the issue in perspective. In a typical year, there are about 50 to 100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted only about thirty formal investigations, mostly involving larger metropolitan hospitals, and has challenged only 13 hospital mergers.

Let me give just one example. In the last year, Columbia Hospital Corporation, through successive mergers with Galen Health Care, Inc., and HCA-Hospital Corporation of America, grew from a system of about 20 hospitals to one involving more than 160 acute care hospitals in 26 states. The staff looked at the competitive impact of those mergers in every geographic area where the mergers involved an overlap in hospital ownership by the merging parties. The Commission charged that the mergers raised substantial competitive concerns warranting divestiture of a hospital in only two geographic areas. Columbia agreed, by consent order, to divest the two hospitals at issue in those markets.[19] The consolidation under common ownership of the approximately 160 other hospitals was permitted to proceed without antitrust interference.

The Commission's assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed both by

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19 Columbia Hospital Corporation/Galen Health Care, Inc., No. C-3472, 58 Fed. Reg. 65721 (1993) (consent order); Columbia Healthcare Corporation/HCA-Hospital Corporation of America, No. 941-0005, 59 Fed. Reg. 10389 (March 4, 1994) (consent order accepted for public comment). The Commission also recently issued a consent order blocking Columbia's acquisition of a single hospital in Punta Gorda, Florida. Columbia Hospital Corp., Dkt. No. 9256 (consent order issued May 5, 1994).

a substantial increase in such activity recently -- which suggests that fear of antitrust enforcement has not dampened hospital mergers generally -- and by other observers. Recently, a Health Care Task Force of the American Bar Association concluded that, "Overall antitrust enforcement has not deterred hospital mergers and in fact, the hospital industry has seen a recent wave of mergers."[20] Similarly, a Department of Health and Human Services task force examined the claim that enforcement agencies have become too adversarial in challenging hospital mergers, concluding that the assertion was not supported by the evidence.[21]

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of merger enforcement, the Commission has expressly allowed various types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and

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20 American Bar Association Working Group on Health Care Reform, "Antitrust Implications of Health Care Reform" (May 14, 1993) at 4.

21 Report of the Secretary's Task Force on Hospital Mergers, at 11 (Jan. 1993). The report noted that between 1987 and 1991 the FTC and the Justice Department investigated only 27 of 229 hospital mergers and challenged only 5 transactions. The HHS task force specifically addressed the issue of rural hospital mergers, which has been the subject of some attention of late. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or 'small' urban settings." Id. The task force report supports the Commission's contention that antitrust enforcement does not inhibit efficient mergers in the hospital area. For example, hospital merger and joint venture activity has been so vigorous that an article in Modern Healthcare was entitled "Mergers Thrive Despite Wailing About Adversity." After an examination of the record, the article dismissed the claim that antitrust enforcement inhibited hospital consolidation. Modern Healthcare, Oct. 12, 1992, at 30.

health care financing.[22] These joint ventures appeared likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other competitive services, as a complete merger could.

The great majority of hospital mergers and joint ventures -- like those in most lines of business -- do not endanger competition. Most hospital mergers do not pose a threat to competition because they occur in markets with a substantial number of competitors. Indeed, many hospital mergers may enhance efficiency and promote competition. Similarly, many hospital joint ventures are efficiency-enhancing. Joint ventures can make new technologies available to communities that otherwise could not have them and can spread the cost of ownership of expensive equipment among competing providers. But joint ventures need not be confined to the acquisition of expensive technologies. They may also facilitate the provision of essential services to a community. Thus, it may not be surprising that most hospitals engage in some forms of joint venture activity. To cite but one example, virtually all hospitals acquire many of their day-to-day supplies through buying cooperatives.[23]

But the fact that most hospital mergers and joint ventures are procompetitive (or, at worst, competitively neutral) does not mean that there is no place for antitrust enforcement in hospital markets. Some transactions involving hospitals are anticompetitive, and the Commission seeks to ensure that health care consumers have a sufficient selection of competing providers to be able to shop for the best possible bargain.

In our hospital merger investigations, we examine a broad range of evidence concerning the likely impact of the merger on health care costs. We do not rely on market concentration figures standing alone. One of several factors to be examined is the views of buyers of hospital services including insurance companies, health care plans, and large employers. In many of

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22 University Health, Inc., FTC Dkt No. 9246, 57 Fed. Reg. 44748 (1992) (consent order) (exempting a wide range of support service joint ventures). See Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) (upholding FTC challenge to acquisition of hospital). See also The Reading Hospital, 113 F.T.C. 285 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory, and biomedical equipment repair services).

23 See Nearly All Hospitals Use Group Purchasing, Modern Healthcare (Dec. 24-31, 1990), at 40.

these investigations, these buyers have stated that competition among hospitals is important because it permits them to get better deals. When we review hospital mergers, we consider whether the merger will help or hurt payors and health care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, hospitals may be able to acquire market power and resist such cost-containment efforts.

Finally, let me address the argument that merger enforcement in the health care area actually leads to higher, not lower, health care costs. The argument we hear with increasing frequency is that competition among hospitals should not be encouraged because it leads to costly duplication of services and facilities. This argument was made to the Commission in defense of a proposed merger a few years ago. The Commission found that the argument was contradicted by a great deal of evidence in that case, including internal hospital documents stating that "increasing competition in the health care sector . . . will allow natural market forces to slow the price spiral."[24]

The Commission's experience in merger enforcement in the health care area has demonstrated that mergers can result in the elimination of duplicative services. Depending on the specific market conditions, this can be pro-competitive or anticompetitive. In some circumstances, elimination of redundant underutilized facilities can improve the effectiveness of operating those that remain. In other circumstances, however, where demand supports the existing level of supply of services, care must be taken to ensure that eliminating duplication does not become simply an excuse for avoiding competition.

B. Exemptions for Professionals

Current proposals for an antitrust exemption for physicians focus on physicians' dealings with purchasers and payors of health care services. Today many physicians compete to be selected by one or more health care plans. Through this competition among physicians, plans seek to employ enough quality physicians without paying unnecessarily high prices. One exemption supported by certain health care professionals would permit competing physicians to eliminate competition by joining together and, without engaging in any risk sharing or integration of their practices or finances, collectively bargaining with large purchasers and payors of health care services.

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24 Hospital Corp. of America, 106 F.T.C. 361, 478-87 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

Purchasers and payors that represent a large number of consumers may have sufficient clout and knowledge to bargain aggressively with physicians and other health care providers to obtain lower charges and adherence to a variety of cost-containment measures. An exemption allowing sellers of health care services to aggregate for bargaining purposes may, however, enable providers to defeat legitimate cost containment efforts that benefit consumers.

The argument for exempting health care providers' joint bargaining from antitrust scrutiny is based on the questionable premise that health care purchasers possess market power and can therefore artificially depress health care prices. In most markets, however, there appear to be a large number of medical care alternatives, including Blue Cross and Blue Shield plans, numerous commercial insurers, HMOs, and other firms that offer health insurance or benefits. In the absence of market power on the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but rather could give physicians unconstrained market power and the ability to raise prices for health care services. Even in circumstances in which the number of payors is limited, we are not aware of any evidence to suggest that allowing physicians to collaborate in negotiating prices will lead to any benefits to consumers.

But we need not rely on theories to see what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the Michigan State Medical Society case I mentioned. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but physicians agreed among themselves that they would not compete over the terms they would accept from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society. This agreement resulted in higher quality-adjusted prices.

No antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients and profession; that is clearly legal under the antitrust laws. But as the Commission and court decisions make clear, the collective judgment of health care providers concerning what patients should want can differ markedly from what patients themselves are asking for already in the marketplace. The point is straightforward. Physicians can engage in forceful advocacy and provide information to health

plans without an antitrust exemption.[25] The Commission has made clear in its remedial orders governing physician boycotts that physicians may nonetheless jointly provide information to payors (or insurers).[26] But an antitrust exemption for "collective negotiations" could permit providers to override consumer choice and harm our economy.

Lately we have also heard the claim that antitrust enforcement interferes with responsible self-regulation by groups of health care providers, and that antitrust prevents such groups from addressing problems of fraud and abuse. Let me assure you that this simply is not the case. Antitrust law does not prevent professional associations from disciplining or expelling members who do not meet appropriate quality of care standards, or who engage in false, deceptive, or other abusive behavior. Many Commission orders involving health care professionals contain provisions explicitly permitting the regulation of false and deceptive dissemination of information.[27] As the Commission emphasized in its 1979 opinion in the AMA case, professional associations "have a valuable and unique role to play" regarding deceptive and oppressive conduct by their members.[28] Such programs can provide valuable information to patients and others who pay for medical care, and, as long as they are properly structured, present no antitrust concerns.

The ability of antitrust law to accommodate professional self-regulation that benefits consumers also is illustrated by a Commission advisory opinion recently issued to the American Medical Association and the Chicago Medical Society.[29] These organizations requested the Commission's opinion on the legality of the proposed system of medical society peer review of

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25 The Commission's Analysis of Proposed Consent Order to Aid Public Comment in the Chain Pharmacy Association matter illustrates this distinction. Chain Pharmacy Ass'n of New York State, Inc., Dkt. No. 9227, 56 Fed. Reg. 12534, 12541 (1991).

26 See e.g., Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175, 180-81 (1988) (consent order); Michigan State Medical Society, 101 F.T.C. 191, 307-08, 314 (1983).

27 See American Psychological Ass'n, C-3406, 58 Fed. Reg. 557 (1993); National Ass'n of Social Workers, C-3416, 57 Fed. Reg. 61424 (1992).

28 American Medical Ass'n, 94 F.T.C. at 1029.

29 Letter from Donald S. Clark, FTC Secretary to Kirk B. Johnson, General Counsel, American Medical Association, and John M. Peterson (February 14, 1994).

physicians' fees that AMA intends to urge its state and local societies to implement. More than a decade ago, in an advisory opinion issued to the Iowa Dental Association,[30] the Commission approved the proposed operation of a fee review system that was voluntary for all parties, advisory, and confidential. The system proposed by AMA and CMS is similar in many respects to that considered in Iowa Dental, but has three significant differences: (1) members of medical societies would be required to participate in peer review proceedings; (2) physicians would be subject to discipline for certain fee practices; (3) and the fact of a disciplinary action against a physician would be made public.

The Commission approved the operation of most, though not all, of the proposed fee review system. The Commission's opinion reaffirms the principle that, with appropriate safeguards, advisory fee review is likely to promote competition by giving patients and insurers information about the basis for a fee and an informed opinion about its reasonableness. The opinion goes on to state that requiring physicians to participate in advisory peer review proceedings as a condition of medical society membership is reasonably related to making information available to consumers, and is not likely to endanger competition. The opinion further states that imposing discipline where the fee review reveals that a physician has engaged in fraud, deception, or other abusive practices would not jeopardize competition. Making legitimate disciplinary actions public likewise would not endanger competition.

At the same time, the Commission reaffirmed the basic antitrust principle that a group of competitors may not regulate the fees charged by its members. Accordingly, the Commission did not approve the disciplinary program to the extent that it contemplated authorizing medical societies to discipline members on the basis of fee levels alone, without regard to the presence of abusive conduct. Such a program, the Commission concluded, would pose a substantial likelihood of injury to consumers. The Commission emphasized, however, that AMA and CMS could take other steps -- such as requiring physicians to disclose to patients in advance certain information about price -- in order to address the problem of information disparities in markets for medical services.

Conclusion

The Commission wants to reiterate the two principal points of today's testimony. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care markets.

Thank you for the opportunity to present this testimony. I would be happy to answer your questions.

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30 99 F.T.C. 648 (1982).

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of the Director
Bureau of Competition

MAY 24 1994

The Honorable Daniel Patrick Moynihan
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I appreciate having had the opportunity to appear before the Committee on May 12, 1994. I would like to address briefly, but more fully than was possible on that occasion, an issue that was raised concerning the ability of physician-organized health plans to compete with insurance companies. Please add this further statement to the record of that hearing.

There appears to be a feeling among many doctors that they are not permitted under the antitrust laws to compete on an equal footing with insurance companies. This is not the case. As I will explain, doctors may participate in a number of ways in plans that compete with insurers. The constraints imposed by the antitrust laws are few and are directed to specific types of activities that carry a substantial risk of harm to consumers.

There can be no question that physicians may establish and operate plans that are directly competitive with insurance companies, including companies similar to traditional Blue Shield plans or IPA-type health maintenance organizations. The Commission has not taken law enforcement action against such physician health plans. In fact, the Commission's Enforcement Policy Statement on Agreements to Control Medical Prepayment Plans[1], published in 1981, stated that agreements among members of a physician group to operate medical prepayment plans are not inherently violative of the law. Rather, the Commission stated, antitrust problems are likely to arise if the plan is formed for an anticompetitive purpose; if plan's formation eliminates, or is likely to eliminate, substantial potential competition from other plans; or if the plan is operated in a way that, on balance, has significant anticompetitive effects.

In addition, as long ago as 1984 the Commission's staff stated in an advisory opinion that members of an IPA/HMO could collectively negotiate the capitation rate they accepted from the HMO and agree among themselves on the fee schedule used to

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[1] 46 Fed. Reg. 48,982 (1981).

distribute the capitation payment among IPA members.[2] This conclusion was reiterated just last fall in a staff opinion letter to a physician-controlled radiology network that proposed to accept capitation contracts from payers.[3]

In the instances discussed above, the physician members of the plan assumed substantial financial risk in connection with the plan's operation, through some type of commitment to provide specified medical care to a covered population in exchange for a fixed monthly payment. In other words, the organizations assumed some or all of the risk usually borne by an insurance company or self-insured employer. If, on the other hand, physicians chose not to bear any insurance or other substantial financial risk, they still can participate actively in managed care plans. Physician-controlled preferred provider organizations can, and do, operate without an agreement among the members of the organization on the prices they will charge for medical services in their individual practices. As was stated in a recently issued staff advisory opinion, an organization can use a variation of the "messenger" approach to price formation, under which an agent of the physician group gives to individual payers price and other information about the group's physicians, and transmits proposed contract terms, including proposed fee schedules to be used under such contracts, to physicians for their individual consideration. So long as the decisions on whether to accept a particular contract are in fact made independently by each member of the group, such arrangements avoid an agreement on price among the participating physicians and thus the antitrust issues that flow from such agreements.[4] These organizations can perform many of the other functions usually undertaken by risk-sharing plans, including joint marketing to third-party payers, quality assurance, utilization review, and administrative services.

However, doctors cannot, consistent with the antitrust laws, agree among themselves on the prices they will charge for their services without substantially integrating their practices in some way or sharing a substantial risk of loss if the group cannot compete successfully with other health plans. This is not a mere formalism, but is rooted in the essential purpose of the

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[2] Letter from Arthur N. Lerner, Assistant Director, to Gilbert M. Frimet (March 22, 1984). See also Hassan v. Independent Practice Associates, P.C., 679 F. Supp. 679 (E.D. Mich. 1988) (physician IPA that provides services to HMO subscribers found not to violate the antitrust laws in private litigation).

[3] Letter from Mark J. Horoschak, Assistant Director, to J. Bert Morgan (Nov. 17, 1993).

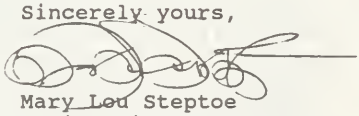
[4] Letter from Mark J. Horoschak, Assistant Director, to J. Bert Morgan (Nov. 17, 1993).

antitrust laws to safeguard the welfare of consumers. Joint price-setting by physicians eliminates price competition among them. When the physician group bears substantial economic risk, each member of the group has a direct stake in the success of the group as a whole, and therefore has an incentive to assure that all physicians practice high quality medicine and avoid unnecessary utilization of services. Members of unintegrated groups that price jointly, on the other hand, have not really established a health plan at all, but simply a physician cartel. These groups try to alter the terms under which insurers purchase services on behalf of consumers, without offering offsetting benefits to competition that flow from the joint pricing.

An agreement among members of a group on common bargaining terms interferes with competition among them on the terms of their contracts with payers. There is every reason to believe that competition among individual providers to enter into contracts with plans benefits consumers through lower costs. There is no reason to believe that allowing otherwise competing providers to bargain as a block with purchasers leads to lower costs, better services, or other benefits to consumers.

Thank you for the opportunity to clarify this point. If I can be of further assistance, please do not hesitate to contact me.

Sincerely yours,



Mary Lou Steptoe
Acting Director
Bureau of Competition

PREPARED STATEMENT OF ROBERT B. WEINTRAUB

My name is Robert B. Weintraub. I am an attorney in New York City and a member of the New York and District of Columbia bars. I am a member of the law firm of Storch & Brenner, in the firm's New York office. The firm is headquartered here in Washington. I testify as an individual, with the views I express being mine and not necessarily those of Storch & Brenner.

In my law practice, I have represented both plaintiffs and defendants in complex civil litigation, including antitrust litigation. I have also represented both defendants, and businesses asserting complaints about the conduct of their competitors, before the federal agencies which enforce the antitrust laws. I appear before you today to testify about antitrust rules in the health care market and on S. 1658, the "Health Care Antitrust Improvements Act of 1993," which is included in multiple health care reform packages.

Supreme Court Justice Thurgood Marshall called the antitrust laws "the Magna Carta of free enterprise . . . [which] are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *United States* v. *Topco Associates, Inc.,* 405 U.S. 596, 610 (1972).

Antitrust enforcement, by private parties as well as government agencies, provides the only mechanism to correct misconduct by individual corporations without imposing continuous and oppressive government regulation on the marketplace as a whole. The antitrust laws allow our basically free market economy to flourish without anticompetitive conduct on the one hand or overweening government regulation on the other. This approach to antitrust enforcement has its roots in the beginning of the 20th century, when the phrase "trust busting" was associated with the presidency of Teddy Roosevelt. Since that time, antitrust enforcement has been both bipartisan and as American as apple pie.

Nevertheless, although the health care industry today is fractured and mainly unconcentrated (with certain exceptions), antitrust lawsuits in the health care industry have been filed in ever-increasing numbers. These lawsuits, and the cost they impose on the judicial system, are spiraling out of control. Many of these lawsuits are essentially meritless. But even meritless antitrust cases can be very expensive to decide because of the complexity of the issues and proof required.

My testimony is based on my experience in private law practice, particularly in the last few years. I have repeatedly been approached by potential clients seeking to sue either health care provider groups including HMOs, hospitals, or both, for alleged antitrust violations. I did not accept any of these cases. In virtually every case, not only was there no antitrust claim present, but the conclusion that no antitrust claim was present was not even a close call. The common thread tying these matters together has been that the potential plaintiff was injured as an individual competitor, not that marketplace competition was injured. And, it is competition in the marketplace—not individual competitors—which the antitrust laws are designed to protect. *Brunswick Corp.* v. *Pueblo Bowl-o-Mat, Inc.,* 429 U.S. 477, 488 (1977). Let me describe in somewhat more detail the types of matters which undermine the system.

In some instances, the plaintiffs or potential plaintiffs are individual doctors who are excluded from a health care provider group. In other instances, the plaintiffs or potential plaintiffs are individual doctors who lost their hospital privileges. Often, the alleged antitrust claim of dismissal or exclusion from the market was fundamentally unsound. In these matters, the doctors were denied the ability to compete in the relevant market because of incidents raising serious questions concerning the doctor's medical practices and competence. In each of these instances, the doctor raised economic—marketplace related—concerns as the real cause underlying exclusion from the market. But the evidence supporting such a conclusion was virtually nonexistent in each instance. Cases like these, however, are often brought by all kinds of plaintiffs against all kinds of defendants. And I believe there should be some mechanism to decrease the costs of such litigation. S. 1658 provides a good framework for discussing such a mechanism.

I should note that I was asked at approximately 4:00 p.m. yesterday to testify here today. Consequently, I am focusing my comments solely on certain aspects of the proposed legislation.

S. 1658 proposes a market power screen which excludes from antitrust scrutiny conduct where the defendant has less than a 20 percent market share. A market power screen may be a useful analytic tool whose time has come.

One recent case illustrating the potential usefulness of a market power screen happened in our home state, Mr. Chairman. The case is *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.,* 996 F.2d 537 (2d Cir. 1993). In Cap-

ital Imaging, the United States Court of Appeals for the Second Circuit upheld the district court's grant of summary judgment dismissing the antitrust claims.

Plaintiff Capital Imaging is a private radiology group of doctors near Albany. The defendants were a small HMO (Mohawk Valley Physicians Health Plan) and the group of physicians organized to provide medical care to the health plan's enrollees, an independent practice association (Mohawk Valley Medical Associates). Id. Plaintiff alleged that it was improperly excluded from providing services to the patients of the HMO.

The Second Circuit upheld dismissal of the suit despite the fact that it agreed with the plaintiff that it was excluded from the independent practice association for improper competitive reasons, in this case to insulate Mohawk Valley's member radiologists from increased competition. Id. Despite the anticompetitive intent, the case was dismissed because defendants' market share ranged between 1.15 percent and 6.75 percent, depending upon the market definition used.

These market share percentages rival the small market shares present in many of the early merger cases from the 1960s which found the challenged acquisition unlawful. Those decisions have never been directly overruled by the Supreme Court and are still good law today. But, it must be remembered that the early merger cases were decided under the amended Section 7 of the Clayton Act. Section 7 applies an "incipiency" standard much more favorable to a plaintiff than the rule of reason standard under Section 1 of the Sherman Act. E.g., Meigher & Weintraub, Celler-Kefauver Act of 1950, in 4 *The Legislative History of the Federal Antitrust Laws and Related Statutes,* ch. 7 at page 3524, 3613 (E. Kintner ed. 1980). The market share percentages present in *Capital Imaging* are so minuscule that in virtually no circumstance could they support a finding of illegality under the rule of reason, because a small defendant (in a rule of reason situation) simply does not have the power it injure competition.

Nevertheless, the litigation lasted four or five years, and I have been told that the defendants in *Capital Imaging* spent $500,000 in legal fees to win that lawsuit where they possessed less than a 7 percent market share. If so, that fact should be of serious concern.

S. 1658 proposes a 20% market threshold. That percentage is a reduction from the 25% threshold contained in companion bill H.R. 3486, and that reduction is a wise step. Even the 20% threshold contained in S. 1658 should not be considered a magic number. While there may be disagreement about precisely where to draw the line, a market power screen, in an appropriate context, has substantial merit.

I understand some individuals and groups consider this legislation to be quote—pro doctor—close quote. There are certain sections of the proposal which, clearly, are just as favorable to HMos and hospitals as to doctors, however. For example, the legislation creates a safe harbor for standard setting and enforcement activities by medical self-regulatory bodies that are designed to promote the quality of health care provided to patients; such enforcement activities would include those taken by HMOs or hospital boards (as well as medical societies), unless done for financial gain. Thus, where a doctor loses hospital privileges over an issue concerning the quality of provided medical treatment, an antitrust suit would be barred unless the malpractice accusations against the doctor were a sham and the true reason for the termination of privileges was competitive gain.

Ultimately, however, most antitrust issues will be decided by the courts in individual litigations. In those circumstances, the best solution is and remains very smart judges; strong judges; judges who have a sense of commerce and industry in America, an evenhanded approach to enforcing the antitrust laws, and the personal strength to grant either motions to dismiss or motions for summary judgment dismissing lawsuits, where appropriate; and, to impose sanctions for frivolous suits, where appropriate.

I appreciate the opportunity to appear before the Senate Finance Committee. I would be happy to answer your questions.

COMMUNICATIONS

STATEMENT OF AETNA LIFE AND CASUALTY COMPANY

As a managed health care company, Aetna is committed to providing high quality health care at a reasonable cost. Due to the fact that the excessive costs and inefficiencies of the current liability system drive up health care costs and restrict access to care, we believe that health care liability reform must be included in the restructuring of our nation's health care system.

People injured by negligent care are entitled to just compensation, and all parties have the right to a prompt, fair, and cost-effective dispute resolution process. It is evident, however, that the current system serves neither plaintiffs nor defendants well. Consequently, Aetna supports reforms that will improve the cost-effectiveness of the liability system, while protecting the rights of both health care consumers and health care providers.

PROBLEMS WITHIN THE LIABILITY SYSTEM

There are several problems within the health care liability system; this statement focuses on those we consider particularly critical and the remedies that can best address them.

The System Is Costly and Inefficient

The American Medical Association has estimated that the liability system adds $9 billion a year in insurance premiums to the nation's health care bill. Yet, studies by RAND (1986) and Tillinghast (1992) have found that only about 50 percent of the total cost of the liability system is realized by claimants. The rest is spent on attorneys' fees and other transaction costs. A system that returns only 50 cents on the dollar is grossly inefficient.

The System is Fraught with Unfounded Claims

The *Harvard Medical Practice Study* (1990), a comprehensive analysis of malpractice litigation, revealed an alarming statistic—approximately 85 percent of malpractice claims were filed in cases in which a panel of physicians found that there was either no negligence or no injury or both. Even when such cases are dismissed, they add to the cost and delay in a system that is already overburdened.

The System Encourages the Practice of Defensive Medicine

As a hedge against potential lawsuits, many health care providers practice positive or negative defensive medicine. Both have serious consequences for health care consumers.

Positive defensive medicine involves ordering medically unnecessary tests, procedures, and referrals. It adds to the cost of health care while subjecting patients to unnecessary and, sometimes invasive, procedures such as Caesarean sections. (Caesarean sections now account for about 25 percent of all deliveries, up from just 5 percent 25 years ago, and are considered a major form of defensive medicine by the National Institute of Health.) The cost of these defensive tactics is estimated at $15 billion annually by the AMA. A study conducted by Lewin-VHI, Inc. a health care consulting firm, found that $35.8 billion in defensive medicine costs could be saved during a five-year period through changes to the liability system.

Negative defensive medicine involves the refusal to offer medical services because of fear of liability.

- According to a 1992 survey by the American College of Obstetricians and Gynecologists, 12.2 percent of obstetricians surveyed are no longer delivering babies and 10.4 percent have decreased the number of deliveries solely because of the risk of malpractice suits.

- As reported in the *Journal of the American Medical Association,* (1/26/90), large numbers of family physicians have also stopped delivering babies; more than half in some states including Utah, Nevada, and Alabama. About 25 percent in most states.
- The liability-driven access problem is not confined to obstetrics. According to a survey conducted by the American College of Surgeons, 40 percent of surgeons were no longer accepting high-risk cases in consultation and 28 percent were not performing certain procedures solely because of the risk of lawsuits.

REFORMS TO ADDRESS PROBLEMS

A discussion of some of the reforms that Aetna believes will restore greater balance and efficiency to the system follows. (A more comprehensive overview of these and other reforms is attached to this statement.)

Early Neutral Evaluation

Early Neutral Evaluation (ENE) is an alternative dispute resolution process designed to encourage the early settlement of those cases that can appropriately be settled outside of the judicial system, while enabling the courts to deal more effectively with those cases that proceed to trial. The ENE process Aetna proposes is modeled after the successful ENE program implemented in the Northern California Federal District Court.

An ENE session is held early in the litigation, before the parties have engaged in substantial discovery but after they have had time to develop the basics of their case. The evaluation includes a frank assessment of the merits of the case by a qualified, neutral evaluator. ENE compels the parties to critically confront their positions and examine the strengths and weaknesses of their cases. The evaluator's assessment serves as a "reality check" for parties and lawyers, which may bring frivolous matters to a halt, or short of that, alter expectations. ENE sets the stage for an early, realistic, settlement offer. However, if settlement is not feasible, the evaluator helps the parties reduce the scope of the dispute and fashion a discovery plan.

Rosenberg and Folberg, University of San Francisco School of Law, recently evaluated the Northern District of California's ENE program. They found that ENE facilitated the early, fair resolution of cases, while saving time and money:

- The majority of participants were satisfied with the process and believed it was worth the resources devoted to it;
- While the percentage of those going through the process who reported saving money approximately equaled the percentage who reported that the process resulted in a net financial cost, those who saved reported saving more than ten dollars for every dollar spent by those who reported a net cost. That is, net cost-savings exceeded total costs by a ratio of 10 to 1;
- In about half the ENE cases, the time to disposition was measurably shortened; and
- The majority of parties and attorneys learned information in the ENE session that led to what they believed to be a fairer resolution of their case.

Expedited Settlement Offer

The Expedited Settlement Offer (ESO) is a reform option that can accompany ENE. Under an ESO process, parties who refuse a reasonable offer and proceed to trial could be responsible for opponent's legal fees if the verdict is not a substantial improvement over the offer.

Certificate of Merit

A certificate of merit is a certification by the plaintiff attorney that the health care liability case being presented is a genuinely arguable case, backed by expert opinion. Under the proposed reform, failure to file a certificate would be grounds for dismissal.

About 12 states have required certificates of merit for medical malpractice actions since the mid-80s. According to the American Medical Association, many states have found them effective in weeding out frivolous suits. Although cost savings have not been calculated, savings are expected to arise from: 1) elimination or early dismissal of non-meritorious suits; 2) prevention of the naming of, or early dismissal of, peripheral or non-involved defendants; 3) reduction in claims filed to toll the Statute of Limitations; and 4) if sanctions are imposed for abuses (e.g., false allegations), possible reimbursement of expenses.

Practice Guidelines as a Rebuttable Presumption

Practice guidelines are specifications for managing particular clinical problems and are intended to improve the outcome of medical care by increasing adherence to standards of care.

As the 1990 Harvard study found, too many malpractice claims arise from cases where there is no negligence. This suggests that many litigants and their lawyers have no clear idea of whether or not the standard of care was met in their particular case. In addition, many patients are currently subject to unnecessary tests and treatments by physicians seeking to protect themselves against potential lawsuits. Others have limited access to high risk specialty services.

Determining negligence through the use of uniform, national practice guidelines, federally developed with a broad base of collaborative input, potentially addresses all of these problems. Under the proposed reform measure, compliance with practice guidelines could be introduced by the defendant and, if introduced, would establish a rebuttable presumption that the services prescribed by the guidelines is the appropriate standard of care. By clarifying the standard of care, practice guidelines would reduce the number of unfounded suits. Moreover, with practice guidelines to follow and depend upon, physicians would be less likely to provide services beyond the appropriate treatment specified in the guidelines and less inclined to stop providing high risk services.

Elimination of the Collateral Source Rule

The collateral source rule prohibits defendants from introducing evidence that expenses incurred by an injured plaintiff have already been or will be paid by another source such as health or disability insurance. Consequently, the plaintiff can receive double payment for economic loss. A RAND study by Danzon (1986) found that collateral source reform reduced medical malpractice claim cost by 11–18 percent and claim frequency by 14 percent. A 1989 study by Sloan, Mergenhagen, and Bovbjerg, found that collateral source reform reduced claim costs by 21 percent.

Under Aetna's proposed reform, proof of economic losses that have been, or will be paid by a collateral source would not be admissible, and both contractual and statutory subrogation would be eliminated.

Abolition of Joint and Several Liability

Under the doctrine of joint and several liability, any defendant can be liable for the entire amount of damages regardless of the defendant's degree of fault. The joint and several rule encourages pursuit of the "deep pocket" defendant instead of those most responsible for the harm. Fairness dictates the abolition of joint and several liability, for at least non-economic damages, in favor of several liability, wherein defendants pay in relation to their actual contribution to the harm.

CONCLUSION

Aetna believes that the reforms we propose will result in a more efficient and equitable distribution of health care dollars, while reducing the overall costs associated with health care. We appreciate the opportunity to submit this statement.

Attachment.

AETNA FEDERAL HEALTH CARE LIABILITY REFORMS

EARLY NEUTRAL EVALUATION

Early neutral evaluation (ENE) would be implemented on a pilot basis. Grants would be offered to 5 states to implement the program over a three year period in medical malpractice cases. Renewal and expansion of the program would depend upon the results of an evaluation.

- Modeled after the successful ENE program in the Northern District of California.
- *Evaluation Conference:* Central feature would be a confidential 2–4 hour case evaluation conference that takes place within 120 days after a complaint is served.

—The session would be held before the parties have engaged in substantial discovery but after they have had time to develop the basics of their case.

—Session would be hosted by a neutral, experienced, highly respected private attorney appointed by the court. The conference must be attended by lawyers and clients with settlement authority.

—The purpose would be to set the stage for serious settlement discussion and weed out frivolous cases.

- *Neutral Evaluator:* To ensure the neutrality of the evaluator, normally, the parties would not select the person. They may, however, interpose objections on the ground of conflict of interest to the evaluator appointed by the court.

  —In selecting evaluators, court would apply three principal criteria: (1) reputation for good judgment and fairness; (2) experience in litigation; and (3) experience in the subject matter of the lawsuit.

- *Format:* Court would not impose a rigid format for the evaluation session because an experienced, neutral evaluator should have the flexibility to tailor a procedure to the unique needs of a case. However, the program would have the following components:
  —*Written Evaluation Statement:* Delivered by each party to evaluator and other party at least seven days prior to ENE session. (Limited to 10 double-spaced pages.) Must: 1) include identification of legal and factual issues, the early resolution of which might reduce the scope of the dispute or contribute to the productivity of settlement discussions; and 2) suggest which discovery promises to contribute most to expediting case preparation and equipping the parties to assess the strengths and weaknesses of their positions. This document would not be admissible in court in the instant action.

- *Case Presentations:* During the ENE session, each party would make a 15–30 minute presentation of its position (may use documents to explain or support contentions). Evaluator may ask questions, but parties may not ask questions or make comments during the opposing side's presentation. The rules of evidence would not apply at this unrecorded session.
- *Defining the Dispute:* Evaluator would work with counsel to clarify the issues and reduce the scope of the dispute by defining areas of agreement and disagreement.
- *Assessment and Settlement Exploration:* The evaluator may attempt to mediate a settlement. If both parties consent, the evaluator may caucus privately with each side. The evaluator may candidly assess the strengths and weaknesses of the arguments and evidence on both liability and damages. Only if both parties consent, the evaluator may offer a valuation of the case.
- *Managed Discovery Plan:* If settlement negotiations are unsuccessful because one or both of the parties and/or the evaluator lack sufficient information to place a value on the case, the evaluator would work with the parties to develop a managed discovery plan. The plan would focus upon uncovering information needed to settle the case (rather than take it to trial). The evaluator would set a time for completion of the managed discovery plan.
- *Follow-Up Session:* If the evaluator or parties believe a follow-up session would be useful, they can discuss the objectives and timing of such a session. The session is permitted only with the consent of everyone involved (including evaluator).

EXPEDITED SETTLEMENT OFFER

The Expedited Settlement Offer (ESO) is a reform option that can accompany ENE. Following the ENE, either party would have the option of seeking to settle the dispute through the ESO process. The process is designed to encourage early settlement by providing incentives for both the plaintiff and the defendant to extend and accept reasonable demands/offers. Inclusion of the ESO option in the ENE pilot would provide an opportunity to assess the impact of limited fee shifting on a relatively low cost and temporary basis.

- Within 120 days after the ENE or the time set by the evaluator for completion of a managed discovery plan, either party would have the option of seeking to settle the dispute on an expedited basis through an Expedited Settlement Offer (ESO).

  —An ESO could include other health care providers or professionals who were involved in the provision of health care services, with their consent.

- The ESO would be an open offer with no specifications (e.g., as to what portion is in satisfaction of net economic loss, pain and suffering, attorney's fees, etc.).
- The offeror is only obligated to stand behind the ESO for 90 days.

  —The offeree may accept the ESO any time during or after the 90 day period, up to verdict, but the offeror can withdraw the ESO at any time after 90 days.
  —If the offer is withdrawn, no shifting of fees, as described below, would occur.

- Evidence of the ESO would not be admissible in court in the instant action.¢

If Defendant Does Not Accept Plaintiff's ESO

- If the defendant does not accept the plaintiff's ESO, and then has judgment entered against it in an amount equal to or exceeding 125% of the ESO (after the award is adjusted for comparative negligence, additur, or remittitur and/or after the award is reviewed on appeal, if one is taken), the defendant would be liable for the plaintiff's reasonable attorney's fees and costs from 90 days after the ESO until the entry of the judgment.

  —This penalty would not exceed the amount of the final judgment.
  —The amount of the penalty could be reduced or eliminated by the court if it finds that:

  (1) defendant had a reasonable basis for rejecting the ESO because the case involved a novel issue of law or complex question of fact (defendant must have documented the same within 90 days after the ESO);
  (2) defendant rejected the ESO because it had a reasonable basis for concluding that it would not be found liable (defendant must have documented the same within 90 days after the ESO); or
  (3) he sanction would result in undue hardship.

If Plaintiff Does Not Accept Defendant's ESO

- If the plaintiff does not accept the defendant's ESO, and then a judgment is entered for the plaintiff in an amount equal to or less than 75% of the ESO (after the award is adjusted for comparative negligence, additur, or remittitur and/or after the award is reviewed on appeal, if one is taken), then the plaintiff would be liable for the defendant's reasonable attorney's fees and costs from 90 days after the ESO until the entry of the judgment.

  —This penalty would not exceed the amount of the final judgment.
  —The amount of the penalty could be reduced or eliminated by the court if it finds that:

  (1)plaintiff had a reasonable basis for rejecting the ESO because the case involved a novel issue of law or complex question of fact (plaintiff must have documented the same within 90 days after the ESO); or
  (2)the sanction would result in undue hardship.

  —The penalty owed by plaintiff would be offset against the judgment (i.e., the amount owed by defendant would be reduced by the amount of plaintiff's penalty).
- If the plaintiff does not accept the defendant's ESO and does not prevail, then the court would determine if the action was frivolous.

  —If the court finds the action was frivolous, the court shall require the plaintiff's attorney, the plaintiff, or both to pay the defendant's reasonable attorney's fees and costs from 90 days after the ESO until the entry of the judgment.

STANDARDS FOR ALL CASES THAT GO TO TRIAL

(With or Without ENE/Expedited Settlement Offer)

LIABILITY DEFENSES

Use of Practice Guidelines as a Rebuttable Presumption

- National practice guidelines would be developed under the direction of the Agency for Health Care Policy and Research (AHCPR) or a similar agency within the HHS Department.
- Compliance with these guidelines may be introduced by the defendant and, if introduced, shall establish a rebuttable presumption that the services prescribed by the guidelines is the appropriate standard of care.
- Practice guidelines would be used in the following manner to make malpractice determinations:

  —Defendants would win dismissal of the case against them if they can prove that: (1) they adhered to practice guidelines that existed at the time of the alleged malpractice; (2) the guidelines were the correct guidelines to apply; and (3) the guidelines applied to the patient's condition at the time of the alleged injury.

- Implemented with a seven year sunset; with re-authorization based on the results of an evaluation.

Informed Consent As an Affirmative Defense

- Disclosure standards for health care providers and professionals would be clarified. Strong informed consent defense language would be included in the legislation.

PROVISIONS ADDRESSING DAMAGES

Collateral Source

- Proof of economic losses that have been, or will be, paid by collateral source is not admissible.
- Subrogation, both contractual and statutory, would be eliminated.

Joint and Several Liability

- Joint and several liability would be abolished in favor of several liability, wherein defendants pay in relation to actual contribution to the harm. (Plaintiff assumes burden of own contribution to the harm.)
- Any uncollectable or "orphan" shares that represent economic loss would be reallocated among the parties, including the plaintiff, according to each party's percentage of contribution to the harm.
- Any person who previously settled with the plaintiff would be included in the apportionment process, all factual evidence would be admitted except the amount of the settlement.

Punitive Damages

- The circumstances under which punitive damages may be assessed would be defined more clearly.

  —Punitive damages would be given only upon a showing by clear and convincing evidence that the defendant (or defendant's agent) engaged in conduct which is specifically intended to cause tangible or intangible serious injury or conduct that is carried out both with a conscious, flagrant indifference to the rights of the plaintiff and with a subjective awareness that such conduct will result in tangible serious injury.

- At the discretion of the defendant, punitives would be bifurcated from the jury trial on compensatory damages.
- Standards to apply in cases of vicarious liability would be clarified and tightened.

  —Punitive damages would not be assessed against a principal for an act or omission of its agent/employee unless a plaintiff establishes by clear and convincing evidence that: 1) the agent/employee's conduct met the above standard; and 2) a superior officer of the principal, in the exercise of policy-making authority, authorized, participated in, or ratified the act or omission.

Periodic Payment of Future Damages

- Defendant may elect to pay future damages exceeding $100,000 on a periodic basis.

  —The future damages to be paid on a periodic basis would be reduced to present value.

  —Periodic payments cease upon plaintiff's death or return to work (except for loss of future earnings in the case of death).

OTHER

Frivolous Actions

- Every pleading, motion, and other paper shall be signed by the attorney of record, or a party, if not represented by an attorney. The signature constitutes a certificate that to the best of the person's knowledge, information, and belief, the pleading or motion is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not imposed for an improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.
- If a pleading, motion, or other paper is signed in violation of this provision, the court shall impose upon the person who signed it or a represented party, or both, an appropriate sanction, which may include an order to pay to the other party the amount of reasonable expenses incurred because of the filing, including reasonable attorneys fees.

Statute of Limitation

- Would establish a two year statute of limitations with an extension for minors.

Attorney Disclosure

- At the time of hiring, attorneys representing any parties involved in a medical malpractice action would be required to disclose: 1) the estimated probability of success on the action; 2) the estimated number of hours needed to handle the action; 3) an estimate of the attorney fee required and whether any costs will be assessed outside the contingency fee arrangement; and 4) an alternative fee type or rate (hourly or contingency) if available.
- At the close of the action, an attorney would provide to the client and the court, if the action was litigated, a full documented disclosure of the hours spent, a description of the work conducted, the total compensation received, and the calculated hourly fee concerning the action.

—Failure to provide the required information would result in a fee limit of 10 percent of the award.

Certificate of Merit

- Would apply to all medical malpractice actions.
- A report, completed by a qualified medical professional, certifying that there is a reasonable and meritorious cause for the filing of the action, would accompany the complaint when the suit is filed (or within 90 days of filing under some circumstances).

—The medical professional completing the report would meet all qualifications of a trial expert.

—A separate report would be filed for each defendant named (or subsequently named) in the complaint.

—When the plaintiff intends to rely on the doctrine of "res ipsa loquitur," the report would state that, in the opinion of the reviewing medical professional, negligence has occurred.

—When the plaintiff intends to rely on the doctrine of failure to inform of the consequences of the procedure, the report would state that the reviewing medical professional concluded that a reasonable health professional would have informed the patient of the consequences.

- Failure to file a certificate would be grounds for dismissal.

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of the American Academy of Family Physicians, an organization representing more than 79,000 practicing physicians, residents and medical students, please accept this statement for the record for the May 12, 1994 Hearing on Health Care Reform and Medical Malpractice and Antitrust Issues.

The Academy strongly supports medical liability and antitrust reform within health care reform legislation. We are extremely concerned about the impact of the medical liability crisis on access to health care services and overall system costs. We are also concerned that present antitrust law does not provide the flexibility required for physicians to address access, quality and cost issues under a reformed health care system.

Medical Liability

Regarding access, the medical liability problem poses its most serious threat to women's health care. In rural areas, inner cities, and economically depressed communities, which have difficulties attracting qualified medical care providers, a virtual exodus of obstetric providers has occurred.

Family physicians are an important source of obstetric care in these underserved areas: data from the 1990 National Ambulatory Medical Care Survey (NAAMCS) indicate that nationwide, 18 percent of office visits for normal pregnancy care are to family physicians/general practitioners. In rural areas, family physicians provide two-thirds of the available obstetrical care.

Unfortunately, in a recent survey of AAFP members, one out of four family physicians who previously provided obstetrical services reported having discontinued those services due to the cost or unavailability of medical liability insurance. Ten percent reported limiting the type of obstetrical care they provide. Approximately 62 percent of family physicians have given up obstetrics altogether.

Regarding cost issues, skyrocketing medical malpractice insurance premiums result in significant increases in health care costs, particularly in rural and under-

served areas. Physician and hospital liability insurance premiums totalled $9.2 billion in 1991, and have been growing at four times the rate of inflation.

In 1992, family physicians paid an average of $5,959 annually for the lowest amount of medical liability insurance, $7,053 if they also provided obstetric services. The discrepancy widens with greater insurance coverage.

A 1993 report by Lewin-VHI estimated that defensive medicine added $25 billion to health care costs in 1991. The study further reported that the U.S. could save $35.8 billion over five years by eliminating defensive medicine practices. In a September, 1993 report, the Office of Technology Assessment reported that a reasonable ceiling on noneconomic damages is the most effective way to contain medical liability costs. And the 1994 report of the Physician Payment Review Commission recommends scheduling noneconomic damage payments, collateral award offsets, periodic payments of awards, scheduled attorneys' contingent fees, joint and several liability reform, reduction in statutes of limitation and binding alternative dispute resolution systems.

Medical Liability Recommendations

The Academy supports federal tort reforms including a $250,000 limit on noneconomic damages, reducing awards by the amount of compensation from collateral sources, allowing periodic payment of awards over $100,000, limiting attorneys' contingency fees, and replacing joint and several liability with proportionate liability among the defendants in a case.

We also support a modified statute of limitations that would require a claim to be filed within two years from the date that the alleged injury should have been discovered, but not more than four years from the date of the alleged injury. For alleged injury to children under age six, a claim should be filed within four years from the date the alleged injury should have been discovered.

In addition, we support incentives for states to establish alternative dispute resolution (ADR) systems, including no fault, fault-based or binding arbitration systems. We also support allowing parties to challenge the ADR outcome in court—but if the court decision is less favorable than the ADR decision, the filing party should pay all legal fees.

Finally, we support recurring that an expert affidavit accompany every claim to certify the claim has merit. The affidavit should be from a specialist who practices in the same medical specialty as the defendant and who has knowledge and expertise in that area.

Antitrust

The Academy is troubled about present antitrust law for two principle reasons, concerns that are related to the evolving health care system and the need for antitrust law to reflect these changes.

First, we are concerned about legal barriers to physicians and other providers who attempt to coordinate and/or integrate their services. Under a reformed health care system, physicians will be required to work together to provide the best care for their patients. Strict adherence to traditional antitrust doctrine will be counterproductive to efforts to realign health care system incentives.

While September, 1993, regulations promulgated by the Justice Department and the Federal Trade Commission outline allowable collective activities by health care providers, including the provision of information by physicians to purchasers of health care services, and physician network joint ventures, they are incomplete as written. Specifically, while the guidelines describe federal enforcement activities, they offer inadequate protection for physicians and other providers against civil lawsuits brought under antitrust statute.

Second, the Academy is concerned about the impact of antitrust law on physicians' abilities to negotiate fee schedules with enormous plans or alliances. Even without health care reform, consumers are moving into organized, integrated health plans, which fundamentally alters the market for physician services. Physicians are no longer able to charge market rates; fees for services are established by the plans or alliances in which they participate. Furthermore, as the insurance market is consolidated, at least some areas of the country will be left with health plans that are the sole buyer of medical services.

Given this likelihood, physicians must have some leverage with which to negotiate fair fee schedules. While some health care proposals allow for some collective action by physicians, they do not extend this principle to physician relationships with health plans that are the sole buyer of services in the region. Even the courts have begun to recognize that collective negotiation is the only way that physicians can level the bargaining imbalance when confronted with payers who dictate fee schedules.

Antitrust Recommendations

1. The Academy recommends codifying the DOJ/FTC antitrust guidelines and limiting damages to single—rather than treble—amounts for antitrust claims against any health care collaborative venture that applies for and receives a certificate of review.

2. We also recommend that the Attorney General, in consultation with the FTC and HHS, establish competition guidelines that reflect the scope of health care reform, and solicit nominations for additional "safe harbors"—permissible collective activity by health care providers. We also support requiring the two agencies to develop a single set of standards and procedures for expedited case-by-case approval, provide a "certificate of review " to the approved entities, and require that joint activities in the health care industry that technically fall outside the safe harbors be analyzed by the "rule of reason," in which competitive benefits are weighed against competitive harms.

3. We also support codifying as an exemption from antitrust laws negotiations between collective providers and health plans that are the dominant buyer in the region, and requiring the Attorney General to develop specific guidelines defining when a health plan is considered the dominant buyer for a region.

4. We also recommend that a separate antitrust standard be established for rural areas that is not predicated on market share statistics but on whether there is evidence that consumers gain in terms of efficiency and quality of care.

Thank you for your consideration of our views. We would be delighted to work with you on any of these issues.

STATEMENT OF THE AMERICAN ASSOCIATION OF BLOOD BANKS

The American Association of Blood Banks (AABB) urges the enactment of comprehensive, nationwide medical liability reform. The AABB supports caps on noneconomic damages, periodic payment of future damages, limits on contingent attorney fees, and consideration of collateral sources when awarding damages. We also support a uniform statute of limitations for medical malpractice lawsuits and a legal defense for working within medical practice guidelines.

We are pleased that much of the proposed health care reform legislation includes many of these important reforms. However, we are concerned that as currently drafted, the medical malpractice sections of some of these proposals may not cover actions brought against blood centers. Whatever form of medical liability reform is chosen, the AABB urges Congress to adopt legislation applicable to legal actions involving the providers of blood services.

The American Association of Blood Banks (AABB) is the professional medical society for approximately 2,400 community, regional and Red Cross blood centers, hospital-based blood banks and transfusion services and more than 9,000 individuals engaged in blood banking and transfusion medicine. Our member facilities are responsible for collecting virtually all of the nation's blood supply and for transfusing more than 80 percent of the blood used for patient care in the United States. Throughout its 47 year history, the AABB has been dedicated to maintaining a safe and adequate blood supply for the American people.

ALL BLOOD SERVICES PROVIDERS SHOULD BE INCLUDED IN MEDICAL LIABILITY REFORM

The AABB is concerned that as currently drafted, the medical liability reform sections of health care reform legislation may not apply to the liability challenges facing the blood banking community. AABB urges Congress to amend the definitions in the medical liability provisions of the legislation so that medical malpractice claims against blood service providers would clearly be covered.

We have found the following problem in Section 5301(a)(1) of the Health Security Act:

> The Act's liability reforms would apply to all **MEDICAL MALPRACTICE CLAIMS;**
>
> Medical Malpractice Claims are defined (in part) as claims against ". . . **A HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL** . . ."
>
> Health care providers and health care professionals are defined (in part) as **"REQUIRED BY THE LAWS OR REGULATIONS OF THE STATE TO BE LICENSED OR CERTIFIED BY THE STATE."**

The U.S. Food and Drug Administration (FDA) thoroughly and extensively regulates the collection, processing and distribution of blood and blood components. While some states have their own regulatory and licensing programs for blood serv-

ices, most states defer to the FDA and do not provide for state licensure or certification of blood banks. Under the Health Security Act language blood establishments located in states without licensure or certification programs for blood establishments would be excluded from the definition of "health care provider" and, therefore, from inclusion in the bill's medical liability reforms.

As portrayed in the enclosed draft revision, we recommend modifying the definition of health care providers/health care professionals to include those "required by State **OR FEDERAL** laws or regulations to be **REGISTERED,** licensed, or certified to engage in the delivery of such services." This would cover blood centers in states without state licensure. Without our proposed amendment many blood centers might inadvertently be excluded from the federal medical liability reforms proposed.

We also recommend that health care reform legislation include a definition of the term "health care services." Since the states now each have their own unique definitions of this term, this action would further ensure uniformity in the treatment of health care providers and professionals.

To clarify that the medical malpractice provisions of the Health Security Act are applicable to legal actions against blood services providers, we recommend amendment of the bill's definitions so that blood services are clearly covered. We are including with our testimony our proposed definitions that would conform to President Clinton's Health Security Act.

BLOOD SERVICES ARE PERFORMED BY MEDICAL PROFESSIONALS

Including blood services in medical liability reform proposals would not only reduce litigation costs, it is good public policy. Blood services are performed by highly skilled and specialized medical professionals, including physicians, nurses, and allied health professionals. Hospitals and transfusion recipients rely on the medical skill and expertise of blood service providers in collecting, testing and processing blood.

The nature of blood services, the high professional standards to which blood services providers are held, and the necessity of safeguarding the safety and adequacy of the nation's blood supply all require that blood service providers be treated in the same manner as all other health care professionals. Including volunteer blood centers in whatever health reform passes this year will give life to the underlying intent of health care reform: to ensure the availability of all health care services—including blood transfusion—to every citizen.

BLOOD AND LIABILITY

Including blood services providers in medical liability reforms is consistent with state law. By virtue of the state "blood shield statutes" product liability actions against blood services providers are not allowed, and plaintiffs must establish negligence in order to recover court awards against blood services providers. However, since state legislators often do not specifically address whether blood services providers are entitled to the protection of state-enacted medical liability reforms, this issue must be litigated on a state-by-state basis. Resolution may involve complex legal arguments and result in lengthy appeals.

For example, after years of litigation, the California Supreme Court concluded that the collection, processing, and distribution of blood are professional medical services and that blood centers performing these services meet the California Medical Injury Compensation Reform Act's (MICRA) definition of health care provider. The Court decided that because blood banks provide a service that is inextricably identified with human health, they are health dispensaries entitled to the liability protections provided by MICRA.

These are just some of the issues appearing in litigation arising from the period prior to 1985 when there was no laboratory test to screen blood for Human Immunodeficiency Virus (HIV), the virus that causes AIDS. While almost all of these lawsuits are dismissed pre-trial or won in court, the litigation costs required to obtain these rulings are enormous. The AABB believes that these funds would be more appropriately devoted to patient care. We therefore urge Congress to craft Federal medical liability reform legislation so that it is clearly applicable to lawsuits against blood services providers.

HEALTH SECURITY ACT DRAFT REVISED DEFINITIONS FOR SECTION 5301 (b)[1]

(3) HEALTH CARE SERVICES.—The term "health care services" means any service provided by a health care services professional or health care services provider, or by any individual working under the supervision of a health care services professional, that relates to the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

(4) HEALTH CARE SERVICES PROFESSIONAL.—The term "health care services professional" means any individual who provides health care services in a State and who is required by State or Federal laws or regulations to have adequate educational background, training and experience, including professional training as necessary, to assure competent performance, or to be registered, licensed, or certified to provide such services; or who is certified to provide health care services pursuant to a program of education, training, and examination by an accredited institution, professional board, or professional organization.

(5) HEALTH CARE SERVICES PROVIDER.—The term "health care services provider" means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State or Federal laws or regulations to be registered, licensed, or certified to engage in the delivery of such services.

[renumber (5), (6), (7); throughout subtitle substitute "health care services professional" for "health care professional" and "health care services provider" for "health care provider"]

STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 26,000 certified registered nurse anesthetists (hereinafter "CRNAs"), which is 96 percent of the nurse anesthetists in the United States. The AANA appreciates the opportunity to provide testimony regarding our opposition to any weakening of the current antitrust laws. We believe that the current antitrust laws and enforcement are crucial to protect competition and consumer choice in the health care system.

INTRODUCTION

In the administration of anesthesia, CRNAs perform the same functions as physician anesthetists (hereinafter "anesthesiologists") and work in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons; ambulatory surgical centers; health maintenance organizations; preferred provider organizations; and U.S. Public Health Service, Veterans Administration, and military medical facilities. Existing studies demonstrate that the quality of care administered to patients by CRNAs and anesthesiologists is the same. Anesthesia outcomes are affected by such factors as the provider's attention, concentration, and organization, and not whether the provider is a CRNA or an anesthesiologist. That is why the Harvard Medical School Standards in Anesthesia focus on monitoring the patient; the standards are based upon data that indicate that anesthesia incidents are usually caused by lack of attention to detail and insufficient monitoring of the patient.

As anesthesia specialists, CRNAs administer more than 65 percent of the 26 million anesthetics given to patients in the United States each year. CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, enabling these medical facilities to provide obstetrical, surgical, and trauma stabilization services. CRNAs are also front line anesthesia providers in underserved urban areas, providing services for major trauma cases, for example.

While many CRNAs practice in an anesthesia team which includes anesthesiologists and other ancillary support staff, CRNAs also practice as independent providers. Independent CRNAs must compete with anesthesiologists in the marketplace. For this reason, CRNAs have found it necessary to seek the protection of antitrust laws to guard their ability to offer competitive anesthesia services to the public. In light of the power and influence of the medical community, weakening of the antitrust laws would have a negative impact on the ability of CRNAs to compete with anesthesiologists.

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[1] This amendment is supported by: The American Association of Blood Banks (AABB); The American Association of Tissue Banks (AATB); The American Red Cross (ARC); and The Council of Community Blood Centers (CCBC).

HISTORICALLY, SOME ANESTHESIOLOGISTS HAVE ATTEMPTED TO ELIMINATE CRNAS AS COMPETITORS

Before the end of the nineteenth century, surgery had been performed only when death was otherwise certain. By the end of the nineteenth century, two developments the discovery and utilization of anesthesia and the discovery and development of asepsis—resulted in an enormous expansion of the numbers and types of surgeries performed. Consequently, hospital construction flourished as the need grew for operating rooms to accommodate aseptic surgery. Simultaneously, demand grew for anesthesia specialists to focus their attention on the anesthesia care of patients while a physician performed surgery.

To meet their ever increasing need for dedicated and qualified anesthetists, physicians turned increasingly to sisters in Catholic hospitals. Nursing sisters, as well as other registered nurses from a growing number of nurse training programs, practiced anesthesia with wide acceptance.

World War I accelerated the demand for qualified nurse anesthetists. The U.S. government called on all available resources to educate nurses who were needed to provide anesthesia to wounded troops. Advances made in anesthesia administration and nurse anesthesia education during the war contributed to the nurse anesthetists' dominant position in the anesthesia services field.

Even before World War I, however, the growth and acceptance of the nurse anesthesia profession and its training programs provoked anticompetitive reactions from anesthesiologists. In 1911, in a harbinger of future anti-nurse anesthetist activity, counsel for the New York State Medical Society declared that the administration of an anesthetic by a nurse violated the law of the State of New York. The following year, the Ohio State Medical Board passed a resolution stating that only registered physicians could administer anesthesia.

Early efforts to crush the nurse anesthesia profession gained momentum as anesthesiologists organized in their opposition to nurse anesthetists. In 1915, anesthesiologists founded the Interstate Association of Anesthetists (IAA). In 1916, the IAA successfully petitioned the Ohio State Medical Board to withdraw recognition of Cleveland's Lakeside Hospital as an acceptable training school for nurses, and to deny recognition of its graduates as registered nurses, on the grounds that Lakeside's use of nurse anesthetists violated the Ohio Medical Board Acts. Nurses and prominent surgeons alike protested the board's decision, and succeeded in having it reversed.

Similarly, in 1917, the Kentucky State Medical Association, with prompting from organized anesthesiologists, passed a resolution prohibiting members from employing nurse anesthetists or referring cases to hospitals where nurse anesthetists practiced. In a test lawsuit brought by a nurse anesthetist, the Kentucky Court of Appeals ultimately rejected the proposition that the administration of anesthesia by a nurse directed by a physician constituted the unauthorized practice of medicine.

In 1921, another anesthesiologist group, the American Association of Anesthetists, commenced a boycott by adopting a resolution prohibiting its members from teaching nurse anesthetists. Anesthesiologists also moved into the political arena, supporting legislation which would prohibit qualified nurse anesthetists from administering anesthesia. Unlike anesthesiologists, the American College of Surgeons, comprised of physicians who utilized anesthetists, opposed legislative prohibitions of nurse-administered anesthesia. In a 1923 resolution, they opposed all legislative enactments which would prohibit qualified nurses from administering anesthesia.

Surgeon support of nurse anesthetists, however, did not stop the anesthesiologists' efforts to keep nurse anesthetists from practicing their profession. In 1933, the anesthesia section of the Los Angeles County Medical Association, along with two individual anesthesiologists, brought a lawsuit against a nurse anesthetist. Notwithstanding an opinion from the California attorney general that supervised nurse anesthesia was not the practice of medicine, the physicians claimed that nurse anesthetists' administration of anesthesia constituted the illegal practice of medicine. As had other courts, the California court found that the administration of anesthesia under physician direction and supervision was not the practice of medicine.

In 1937, the American Society of Anesthesiologists (ASA) was formed. (The American Association of Nurse Anesthetists had been founded in 1931). Immediately after its inception, the ASA presented a master plan for the eventual elimination of nurse anesthesia to the American College of Surgeons. The plan specified that nurses should not be permitted to continue to provide anesthesia. It also provided, inter alia, that a provision should be included in the Minimum Standards of Hospitals (the forerunners of the Joint Commission on Accreditation of Hospitals' standards) directing that the department of anesthesia in each hospital shall be under the direction and responsibility of a well-trained physician anesthetist. The plan

cautioned, however, "that no legislation should be forced until physician anesthetists can take over the work in a competent way."

World War II increased the number of anesthesiologists. After the war, the anesthesiologists, as they sought to establish themselves in a civilian economy, renewed their activities against CRNAs. Between 1946 and 1948, the ASA launched a campaign to discredit CRNAs in the eyes of the public. The campaign was successful in reducing the numbers of nurses attending nurse anesthesia training programs. The campaign was halted when the American Medical Association, the American College of Surgeons, and the Southern Surgical Society expressed their opposition to the ASA's negative publicity, and expressed their support of, and continued intention to utilize, CRNAs.

In 1947, the ASA adopted an "ethical principle" prohibiting members in good standing from participating in nurse anesthesia programs and from employing or utilizing CRNAs. Measures to enforce the ethical guidelines included the threat to revoke the American Board of Anesthesiology certificates of physicians training nurse anesthetists.

SUCCESSFUL ANTITRUST RELIEF AGAINST ANESTHESIOLOGISTS

CRNAs have successfully prosecuted actions against anesthesiologists for antitrust injury. Appellate Courts have recognized that CRNAs and anesthesiologists can be direct competitors for antitrust purposes, *Bahn* v. *NME* Hospitals, 772 F.22 1467, 1471 (9th Cir. 1985). For example, in *Oltz* v. *St. Peter's Community Hospital,* 861 F.22 1440 (5th Cir. 1988), plaintiff Oltz sued four anesthesiologists and the hospital that granted three anesthesiologists an exclusive contract to provide anesthesia services, alleging violations of section 1 of the Sherman Act. The anesthesiologists settled before trial, paying Oltz $462,500.

In affirming the district court's finding that the hospital joined the conspiracy to terminate Oltz's billing contract with the hospital, the Ninth Circuit noted that the anesthesiologists had "pressured the hospital at St. Peter's to eliminate Oltz as a direct competitor." The anesthesiologists had threatened to leave St. Peter's unless Oltz's independent billing status was terminated. After Oltz's termination, the anesthesiologists offered him a salaried position as an employee in their association, under their direction. Oltz refused. With Oltz gone, the anesthesiologists annual earnings increased by forty to fifty percent. The public interest in competition was vindicated by Oltz's invocation of the antitrust laws.

Relief under state antitrust laws was granted in *State of Maine* v. *Anesthesia Professional Association,* 1984–2 Trade Cas. (CCH) 66,081 (Me. Super. Ct. June 28, 1984). The defendants in the case, the Anesthesia Professional Association (APA) and 19 of its member anesthesiologists, entered into a consent decree with the State of Maine resolving certain issues concerning the anesthesiologists' practice of anesthesiology in Portland, Maine area hospitals. The consent decree prevented the defendants from taking key employment related actions against CRNAs. The relief protecting CRNAs was effective because the consent decree also prohibited the APA and its member anesthesiologists from entering into an exclusive contract with any hospital for the provision of anesthesia services. Thus, the APA anesthesiologists could not monopolize anesthesia services at the hospital at the expense of CRNAs (and other competing anesthesiologists).

The Federal Trade Commission (FTC) has also fashioned effective relief to remedy the ASA's anticompetitive activities. *In re American Society of Anesthesiologists,* 93 F.T.C. 101 (1979), the Commission and the ASA entered into a consent order under which the ASA agreed to end its formal restrictions on methods of anesthesiologist compensation. In the case, the ASA's "ethical guidelines" prohibited anesthesiologists from practicing on any basis other than fee-for-service, i.e., members were not to practice as salaried employees of hospitals. Id. at 102.

The Commission's order in that case, inter alia, prohibited the ASA for a 10-year period from making *any* statement containing an official ASA position that related to anesthesiologists compensation arrangements unless the statement contained and was not inconsistent with the following language:

> It is the official policy of the (ASA] that an anesthesiologist is free to choose whatever arrangement he prefers for compensation of his professional services. *The Society does not consider the arrangement so chosen to be a matter of professional ethics.*

Id. at 105 (emphasis added).

ANTITRUST PROTECTION IN CURRENT ANESTHESIA MARKETPLACE

Current economic practices in the field of anesthesia do not reflect the normal workings of the marketplace. It has been said that they reflect a modern version

of mercantilism in which the winners are those who can most effectively influence the rules of the game, not those who can most efficiently produce the goods or services. A successful market competitor competes, increases choices, and lowers prices. On the other hand, a mercantilist monopolizes, restricts choices, and raises prices.

Attempts have been made by some physicians to keep CRNAs from freely competing in the marketplace by creating barriers to practice. Examples of barriers to practice include, but are not limited to, hospital medical staff bylaws which deny CRNAs clinical practice privileges, specific restrictions on clinical practice privileges of CRNAs, promulgation of inaccurate information about a surgeon's liability for CRNAs, and the formation of large anesthesiologist groups. Whether specific barriers to CRNA practice constitute anticompetitive behavior under the antitrust laws obviously depend on the facts of each case. However, CRNAs want to retain the ability to utilize appropriately the current antitrust protections, for example, conspiracies in restraint of trade, conspiracies to price-fix, attempts to monopolize, threats of boycott or actual boycotts, or group refusals to deal.

1. HOSPITAL MEDICAL STAFF BYLAWS WHICH DENY CRNAS CLINICAL PRACTICE PRIVILEGES

Some physicians have created hospital medical staff bylaws that effectively eliminate the opportunity for independent CRNA practice. In one such case, the hospital, upon recommendation of a group of anesthesiologists changed its bylaws to state that "nurse anesthetists could only practice in the institution if they were employees of the physician anesthesiologists." This bylaw effectively restricts an independent CRNA from applying for medical staff clinical practice privileges. Without the opportunity to obtain medical staff clinical practice privileges at a hospital, independent CRNAs do not have the ability to administer anesthesia to patients in that facility. Therefore, they would have to become employees of an anesthesiologist group or some other entity in order to provide anesthesia in that hospital. When CRNAs are employees of anesthesiologists, though, the price of their anesthesia service is set by the employer at what would probably be a higher rate than what an independent CRNA would charge for the same service. As a result, the patients at that hospital would lose their competitive choice.

2. SPECIFIC RESTRICTIONS ON CLINICAL PRACTICE PRIVILEGES OF CRNAS

While CRNAs do have the right to practice in many institutions, there have been situations where anesthesiologists, through the medical staff structure, have restricted the scope of practice of CRNAs. If their scope of practice is limited, then CRNAs cannot compete with the "full service" anesthesiologists. Restrictions on scope of practice have included: refusal to grant clinical practice privileges for regional anesthesia, insertion of invasive monitoring lines, and postoperative pain management of patients. Another example of a practice limitation is when a CRNA is only allowed to monitor an obstetrical patient after an anesthesiologist has administered an epidural injection (a regional anesthetic), even though the CRNA is legally qualified to actually administer the epidural injection. Other CRNAs experience unnecessary limitations on which types of patients they may treat. These restrictions on clinical practice privileges are not related to education or ability, but rather to the desire by some physicians to control the scope of practice of their competitors.

3. PROMULGATION OF INACCURATE INFORMATION ABOUT SURGEON'S LIABILITY FOR CRNAS

It is difficult for CRNAs to compete, in the market when anesthesiologists use inaccurate information to persuade surgeons not to utilize CRNA services. In one such situation in Southern California, an anesthesiologist sent promotional and marketing letters to plastic surgeons, ophthalmologists and other physicians stating that the surgeons had increased liability if they used a CRNA rather than an anesthesiologist. It is important to understand that typically in cosmetic plastic surgery, the patient pays for the procedures, as insurance does not cover such operations. Plastic surgeons, recognizing the competitive pricing and high quality of care provided by CRNAs, have utilized these practitioners for many years. However, inaccurate information regarding liability of the surgeons for care provided by CRNAs could have had a significant adverse influence on surgeons' use of nurse anesthetists. The California Association of Nurse Anesthetists was able to use the threat of antitrust action to remedy this situation.

4. FORMATION OF LARGE ANESTHESIOLOGIST GROUPS

In recent months, large anesthesiology groups that have taken over anesthesia services in several hospitals, or in all of the hospitals, in certain major metropolitan areas. In those situations where the anesthesiologist group has an exclusive contract that prohibits competitors from gaining access to the facility, the free market for anesthesia services in those areas is a casualty.

As of January 1, 1994, there was a merger of two anesthesiologist groups (Middle Tennessee Anesthesiology, P.C. and Anesthesiology Consultants of Nashville, PC.), which both served metropolitan Nashville, Tennessee and surrounding Davidson County. The new group, called Anesthesia Medical Group, includes 60 of the 111 non-teaching anesthesiologists serving the metropolitan Nashville area. Anesthesia Medical Group employs 105 of the 175 CRNAs practicing in the same area.

In the Nashville area there are 3,906 staffed hospital beds distributed among 12 hospitals. Anesthesia Medical Group is the sole anesthesia provider in two hospitals comprising one third of the available staffed hospital beds in Nashville. In a third hospital, with 571 staffed beds, the group does not have an exclusive arrangement, but provides approximately 65 percent of the anesthesia.

Therefore, Anesthesia Medical Group contains approximately 54 percent of the practicing anesthesiologists, controls 60 percent of the CRNAs in the area, and has exclusive or nonexclusive access to nearly one half of the staffed hospital beds in the area they serve. No other group of anesthesiologists in the area has over 20 anesthesiologist members.

Anesthesia Medical Group because of its size, is well in excess of the September 15, 1993 antitrust guidelines jointly issued by the U.S. Department of Justice and FTC, which allow a safety zone for physician joint ventures comprised of 20 percent or fewer of the physicians practicing in the relevant geographic market. This new dominant group of anesthesiologists has used its obvious market power to lower the compensation of the CRNAs employed by one of the two merged anesthesia groups.

The group's size constitutes an effort to improve its bargaining position with hospitals and insurance companies. However, such large concentrations of market power create anticompetitive risks and may constitute a violation of the antitrust laws.

AANA OPPOSITION TO WEAKENING EXISTING ANTITRUST LAWS

1. PRESIDENT CLINTON'S "HEALTH SECURITY ACT" ANTITRUST EXEMPTION PROVISIONS

The AANA opposes the provisions in Section 1322(c) of President Clinton's "Health Security Act" (HR 3600/S 1757), which would grant an antitrust exemption to provider groups to collectively negotiate with regional alliances over fee schedules to be paid under fee-for-service plans. Much of our concern arises because, unlike the present judicial tests for state action and Noer-Pennington immunity, Section 1322(c) fails to provide for any real supervision over provider conduct during the fee-setting and fee-negotiation process. Therefore, members of our association, having less negotiating power than dominant provider groups, risk being ignored or excluded entirely from the negotiation process.

In addition, we are concerned that the Health Security Act specifies that fee schedules are "state regulated." Therefore, concerted refusals by anesthesiologists to deal with CRNAs who may not agree to practice restrictions, would not be actionable under the federal antitrust laws. For example, a fee schedule between a provider group and an alliance that reflected a policy not to engage CRNAs who did not work for anesthesiologists would not involve a prohibited boycott, since the refusal to deal with independent CRNAs would be the direct result, not a collateral result, of the agreement. If concerted refusals to deal with CRNAs are immunized from antitrust attack, CRNA independent practice is threatened.

2. HATCH/ARCHER ANTITRUST BILLS (S 1658/HR 3486)

The AANA also opposes the "Health Care Antitrust Improvements Act of 1993" (S 1658/HR 3486), companion bills introduced by Senator Orrin Hatch (R-UT) and Representative Bill Archer (R-TX) respectively. We believe that there is no documented need to expand the "safety zones" created in the September 15, 1993 U.S. Department of Justice/FTC Statement of Antitrust Enforcement Policy in the Health Care Area (hereinafter "antitrust guidelines").

One reason for our opposition is that the bills would exempt certain activities from the antitrust laws if the conduct falls within a safe harbor defined by the legislation. One of the safe harbors is collective activities related to the provision of health care services in which the number of each type of provider or specialty does not exceed 20 percent. (S 1658 states 20 percent, while HR 3486 states 25 percent).

This creates a statutory antitrust bar in situations where 20 percent of the anesthesiologists in a relevant geographic market come together for the express purpose of engaging in anticompetitive behavior, such as attempts to boycott CRNAs or conspiracies to price-fix. Let's create a hypothetical situation where there are 50 anesthesiologists in a relevant geographic market and five hospitals. If 10 anesthesiologists insisted on an exclusive contract with one hospital and refused to work with CRNAs, they would fall within the 20 percent safe harbor. If the same 10 anesthesiologists mandated to that one hospital that they would only work with CRNAs who were employed by their anesthesiology group, they would fall within the 20 percent safe harbor. Taking our hypothetical one step further, each of the five hospitals could have 10 anesthesiologists and fall within the 20 percent safe harbor. The 10 anesthesiologists at each hospital would not even have to collude with each other to create an anticompetitive copycat effect. This means that if the 10 anesthesiologists at one hospital decided to collectively negotiate and raise their fees, the 10 anesthesiologists at each of the other four hospitals could take note of that fact and raise their fees to match. This type of copycat effect would increase costs to the consumer.

Another hypothetical involving the 20 percent safe harbor would be a situation where anesthesiologists could act collectively for the express purpose of keeping managed care entities out of a rural area because managed care entities often utilize cost-effective CRNAs to provide anesthesia. In our hypothetical, a small town of 25,000 may have one hospital and one anesthesiologist group, which consists of two anesthesiologists. Taken alone, the two anesthesiologists may comprise 100 percent of the anesthesiologists in that small town and, therefore, would fall outside of the 20 percent safe harbor. However, the more likely definition of the relevant geographic market for the small town would be one that includes the hypothetical city of 100,000 within 15 miles of the small town. That city has three hospitals and 10 anesthesiology groups. Each of the 10 anesthesiology groups consists of two anesthesiologists. There is no anesthesiology group that has more than 20 percent of the relevant market and, therefore, each anesthesiology group has the protection of the 20 percent safe harbor. If the two anesthesiologists at the small town hospital are added to the 20 anesthesiologists at the city hospitals, the two anesthesiologists at the small town hospital may now be eligible for protection under the 20 percent safe harbor. This could empower the two anesthesiologists at the small town hospital to act collectively to prevent managed care entities, who may rather utilize CRNAs, from moving into their small town.

Currently the U.S. Department of Justice and the FTC have the authority to evaluate whether the conduct in the above hypotheticals fell within the "extraordinary circumstances" exception to the 20 percent safety zone created in the September 15, 1993 U.S. Department of Justice/FTC antitrust guidelines. Under the Hatch/Archer bills, the U.S. Department of Justice and FTC would have no discretion to review these cases because they would fall within a statutory antitrust safe harbor.

A second reason for our opposition to the bills is they create another safe harbor for standard setting and enforcement activities by medical self-regulatory entities, such as the ASA. Standard setting and enforcement activities are defined to include accreditation of practitioners, risk management, practice guidelines, and peer review of medical professionals. These provisions would immunize the ASA Anesthesia Care Team pronouncements from antitrust challenge. The ASA Anesthesia Care Team pronouncements have stated that ideally all anesthesia should be performed by an anesthesiologist, or at minimum by an anesthesia care team (CRNA and anesthesiologist working together). The AANA does not support the ASA Anesthesia Care Team pronouncements because the AANA believes that CRNAs are fully qualified to work alone as private practitioners and should not be restricted to working only as part of an anesthesia care team. CRNAs should have the right to engage in the type of anesthesia practice that they choose.

A third reason for our opposition is that practice guidelines created by the ASA would be immune from antitrust challenge. These practice guidelines could be used to restrict CRNA practice by, for example, requiring that only anesthesiologists could provide regional anesthesia for obstetrical cases.

CONCLUSION

CRNAs have the education and ability to compete in the health care marketplace due to the cost-effectiveness and quality of the services they deliver. However, based on historical and recent experience in the evolving health care marketplace, CRNAs often do not have a level playing field on which to compete. Even with the protection of the current antitrust laws, some anesthesiologists may successfully restrict the

practice of CRNAs or actually exclude CRNAs from hospitals. Without the protection of the current antitrust laws, anesthesiologists may successfully eliminate the practice of their competitors—CRNAs.

The current antitrust laws are intended to preserve competition and promote consumer welfare. Expanding antitrust exemptions beyond what current law permits would only serve to undermine these objectives by eliminating competition, limiting consumer choice, and increasing costs to consumers. Therefore, the American Association of Nurse Anesthetists strongly opposes any weakening of the current antitrust laws.

Thank you for your consideration of our views.

STATEMENT OF THE AMERICAN BOARD OF PROFESSIONAL LIABILITY ATTORNEYS

I want to begin by applauding this committee and every member of Congress who is focusing on our nation's health care system. Clearly, there is much room for improvement and there is no area more important for our government to deal with.

However, in our quest to improve access to health care for all Americans, we must not lose sight of quality. Improved access to physicians is no cure for what ails the system if we cannot assure the public that their physicians are competent.

Reducing the cost of health care will be small consolation if, in the process, we do not reduce the incidence of negligent, incompetent, substandard care in our hospitals.

Let's start with these basic facts—unknown to most of the American public. According to data in studies by Harvard University, the State of California and others, it seems certain that more than 100,000 Americans die and 500,000 are injured each year due to malpractice in hospitals. Hardly any of these incidents come to light. Hardly any of the doctors involved are ever disciplined. The victims themselves—or their families—usually never know that the death or injury was unnecessary and avoidable.

According to the AMA itself, 10% to 14% of the nation's 600,000 physicians have been abusers of alcohol or drugs, or have been psychiatrically impaired. But when was the last time you heard of a patient being told that their doctor had a drinking or drug problem? Never. Routinely, the public receives no information, has no way of protecting itself against these practitioners.

Most doctors are skilled, diligent, selfless people who devote their lives to the care of others and deserve our esteem. But we must recognize that, as a practical matter, the medical profession is totally unpoliced. Bad doctors are rarely disciplined and are allowed to prey on patients repeatedly, without any official body doing anything to stop them or warn future potential victims.

The states don't discipline doctors. According to Public Citizen, only about 2,000 to 3,000 physicians are disciplined each year by state licensing authorities. Most of those are for offenses other than malpractice and, with a few rare exceptions, they all involve nothing more than a slap on the wrist.

Medical societies don't do much either—in fact they usually say it's not their job to help weed out negligent physicians. And most individual doctors just won't get involved, preferring to give a fellow physician the benefit of the doubt.

I am both a neurosurgeon and an attorney and I've represented thousands of patients and their families. I know first hand how widespread and serious this problem is. America needs malpractice reforms that protect patients, not bad doctors. And I urge this Committee to include such reforms in any legislation it passes.

States claim that they lack the money and staff to investigate and prosecute all complaints against physicians. But there are resources available to help them locate the bad doctors and the government should require states to use them.

A study by Tufts University found that insurance companies restrict or cancel the malpractice policies of more than 7,000 doctors every year because of questions about competence or inordinate numbers of malpractice lawsuits. That's only a fraction of the incidents of malpractice, but it's triple the number of doctors who are being disciplined by the states.

A new national health plan should require insurance companies to report to state medical boards when they cancel or restrict a policy. This would enable states to focus their investigations on physicians who are likely to be a public risk and the determine whether any action should be taken against them.

Also, experience shows that physicians who don't carry malpractice insurance are more likely to practice substandard medicine. At the very least, requiring insurance companies to report would allow states to make public the names of doctors who don't have insurance or have had it revoked or severely limited. It would help patients make informed judgments in choosing their doctors.

Another federal reform would be to remake state licensing and disciplinary proceedings public. State medical boards and peer review organizations are usually composed entirely of physicians who often bend over backwards to give their fellow doctors a break. Congress should require that these boards include non-physicians as well.

The federal government should also require states to open licensing and disciplinary hearings to everyone and to make their findings public. Boards should have to issue their findings in disciplinary matters within one year—rather than allowing them to drag on indefinitely as often happens now.

Congress can also improve the watchdog systems that are already in place. For example, the Federal Health Care Financing Administration regularly compiles the mortality rates at hospitals around the country, but provides no information on the causes of death. Why not require its investigators to evaluate whether the death rates are due to factors beyond the hospitals' control or to negligence or substandard care?

Another asset that has been wasted is the National Data Bank—a federally financed computer registry that includes the names of physicians who have been found liable for malpractice, who have paid out settlements to victims in malpractice lawsuits or against who disciplinary actions have been imposed. At present, this valuable information bank is closed to the public. President Clinton has recommended that it be opened and I urge Congress to follow suit.

Unfortunately, our government—at all levels—has not done a very good job of protecting the public from incompetent doctors. In part, that's because most malpractice happens secretly. And it's covered up. The public is unaware of it, as are many of our country's policymakers. As a result, most of what we hear on this subject is from the side of the medical establishment and the insurance industry, whose job it is to protect doctors—apparently even the worst in the profession—even if it is at the expense of the public's safety.

Most of the reform proposals offered by these groups include such things as no-fault plans under which the state or federal governments would pay any claims, which would effectively absolve negligent doctors of liability; caps on damage awards, which would discourage lawsuits by people with legitimate claims; mandatory arbitration outside the courts; and panels to screen for frivolous lawsuits. These last two proposals are tantamount to blocking the courthouse door.

We can see an excellent example of how programs like these fail—protecting bad doctors and providing little or no compensation for victims or protection for the public—in Virginia, where a no-fault system call the "Birth Injury Fund" has been in existence since 1988.

As is stands today, civil lawsuits are the only check against incompetent doctors. Lawsuits against obstetricians—relatively prevalent—usually involve not understandable errors in judgment, but obvious failures by physicians to provide a normal standard of care. In fact, most involve obstetricians who simply weren't there. Either because it was late at night, or because they were busy, or because it was inconvenient, they failed to be present in the labor room when needed. Fetal distress occurred and either went unnoticed or ignored by inexperienced or incompetent hospital staff. When physicians finally arrived, hours later, brain damage had occurred in the baby.

But in Virginia, they have given these obstetricians immunity. For the first five years of the program, not one single award was made to a brain damaged child or its parents. In the 16 months since then, four awards have been made, for a total of $97,000, less than $25,000 each for the four brain damaged children who received awards. $25,000 is a paltry amount to pay for a lifetime of health care, special education and the other needs of a brain damaged child. This is in contrast to the large number of babies who are born brain damaged in Virginia each year, a significant number of whom are victims of physician negligence.

Clearly, this program and others like it are a fraud. They are part of a series of myths the medical and insurance lobbies have been spreading among government officials and the public for many years. Before I conclude, I would like to touch on a few other myths and try to explain their flaws.

One of the greatest hoaxes ever perpetrated on the American people is the defensive medicine myth. Doctors, the myth goes, conduct costly, unnecessary tests on their patients in order to protect themselves from lawsuits, thus driving up the cost of health care.

But the truth is that defensive medicine simply does not exist. It is a contradiction in terms. If tests are being performed that assist the doctor in determining a diagnosis or treatment, then they are not unnecessary and they have nothing to do with protecting against a lawsuit. If a test is unnecessary, if it is irrelevant to a patient's illness, how could it possibly assist in the defense of a malpractice lawsuit?

A lawsuit seeks to show that substandard care led to the injury of a patient. What help is it to a physician in that position to be able to produce irrelevant test results?

If doctors are doing unnecessary tests, they are likely doing it for the money. This is demonstrated by the fact that physicians who own laboratories order four to five times as many tests as do independent physicians. Ordering unnecessary tests is not only bad medicine, it is a crime. Taking someone's money for one's own purposes—whether it is used to purchase unnecessary tests or a yacht—is embezzlement. It is criminal avarice and doctors who engage in it should be prosecuted. It is not only bad medicine, it's a crime and they should be prosecuted for it.

Another often repeated myth is that so-called frivolous lawsuits cause malpractice insurance premiums to rise and thus drive up the cost of health care. But the truth is that approximately $6 billion—less than one percent of the nation's total health care bill—is spent by doctors and hospitals on malpractice insurance. The level of spending is minor in comparison to other costs, but even at this level, insurance companies are making huge profits.

The total amount of all malpractice awards in America is less than the interest companies earn on the investments they make with the premiums they collect. Thus, the billions of dollars paid by doctors in insurance premiums over the years are still in insurance company coffers, leading the General Accounting Office in 1987 to report that liability insurance companies had realized profits in excess of $110 billion during the preceding decade.

According to the Coalition for Consumer Rights, all of the costs associated with medical malpractice—not merely insurance—account for only one percent of total health care expenditures in America. Clearly, when we look at the facts, this statement is true. But if Congress is inclined to do something to hold down the cost of malpractice insurance, the first place it should look is at insurance company profits.

More important, however, if Congress is interested in doing something to hold down the cost and the incidence of medical malpractice, it should look not to the victims of malpractice nor to the lawyers who represent them. It should look to the medical profession.

The problem with the malpractice system is not that there are too many lawsuits, it's that there is too much malpractice. Up to now, the only protection the public has had is civil litigation. The only method of bringing bad doctors to justice and providing information about them to the public has been through the courts. The malpractice reforms I've outlined would not eliminate the need for lawsuits, but they would help to identify incompetent physicians, help to spotlight substandard hospitals, so that, over time, fewer incidents of malpractice will occur.

That's the only type of malpractice reform that will truly help the American people.

Thank you.

STATEMENT OF THE AMERICAN COLLEGE OF NURSE-MIDWIVES

The American College of Nurse-Midwives ("ACNM") has consistently opposed any antitrust exemption in connection with health care reform. ACNM opposes those aspects of section 1322(c) of S. 1757 (Health Security Act) which immunize the federal antitrust laws provider conduct which would otherwise violate section one of the Sherman Act (15 U.S.C. §1). The provisions of this section of the bill would permit health care providers to discuss and agree upon prices and fees, and then to negotiate those fees collectively with health alliances for purposes of developing fee-for-service fee schedules. In effect, this exemption would permit groups of health providers to fix prices for their services—not only with regard to the fee-for-service schedules but, as a result of spillover effects, in connection with negotiations with health plans.

ACNM also opposes S. 1658 and S. 1770, bills which would carve out broad and unnecessary antitrust exemptions for various types of joint conduct among health care providers. ACNM believes that the Statements of Antitrust Enforcement Policy in the Health Care Area, which were issued by the U.S. Department of Justice Antitrust Division and the Federal Trade Commission on September 15, 1993, provide sufficient guidance to health professionals and institutions that wish to avoid the risk of antitrust liability. The broad immunities created by these bills are unnecessary and potentially harmful, not only to consumers but also to health professionals such as certified nurse-midwives ("CNMs") who compete with members of dominant provider groups.

In this Statement, we will address each of these bills separately.

S. 1757 (Health Security Act). Much of our specific concern about the exemption contained in this bill is based upon its failure to provide any real supervision or con-

trol over provider conduct during the process of fee-setting and negotiation. The term "negotiations" is defined in this bill broadly enough to encompass and shelter otherwise blatant price fixing activity and will provide an opportunity for competitor collusion on fees. Legally-permitted opportunities for fee-related collusion are highly likely to spill over into and taint areas where such competitor price fixing is not permitted, such as provider negotiations with health plans. Allowing competitors who have not integrated into provider networks to nevertheless exchange fee information and agree upon fee levels which will be sought from the alliances can only have the inevitable effect of increasing the risk that this information will be used in other, still-prohibited contexts.

This exemption is derived from the existing "state action" antitrust exemption, a court-created immunity which has protected the actions of State governmental agencies, as well as private individuals and entities who act in reliance on, or in obedience to, such state policies, from the federal antitrust laws. Historically, the courts have only permitted such immunity to the extent that conduct which would otherwise violate the antitrust laws is the result of a comprehensive, clearly articulated, and affirmatively expressed state policy to replace competition with regulation for a particular sector of the State's economy. Additionally, the state policy must provide for active supervision of the private conduct by a branch of state government which has enforcement power to detect and prevent abuses. These safeguards are intended to protect consumers.

This section of the bill also extends the Noerr-Pennington doctrine, an exemption which protects lobbying and other efforts to influence governmental decision-making from antitrust enforcement, to provider groups that negotiate with alliances.

Another serious problem with this section is that the statute's formulation of these exemptions is not as explicitiy or as carefully worded as the tests which the United States Supreme Court has developed with respect to these exemptions and does provide for state government supervision. Thus, not only does section 1322 extend what was formerly a narrowly-construed exemption to conduct which would otherwise be considered per se illegal, but it does so in a manner far less rigorous than the courts have employed when ruling upon state-developed exemptions and immunities in this and other industries.

ACNM opposes the antitrust exemption provisions of this bill because it undermines a key original intention of health care reform—to create alliances of business and consumers that could use their combined buying power to keep health care costs down. Joint provider negotiations, however, would permit physicians and other large groups of providers to counter whatever buying power the alliances may have. This is, in fact, the argument raised *in favor of this exemption* by its supporters, but it would change the balance of power. While this change might improve the financial prospects of providers under health care reform it would be highly detrimental to consumers' pocketbooks.

ACNM is aware that the proposed exemption would apply to all categories and groups of health care providers, not just physicians and hospitals and, thus, would supposedly benefit its own members by permitting CNMs to negotiate with the alliances over fees. Thus, superficially, it might appear that CNMs would also be entitled to set fees among themselves, to negotiate fee schedules with alliances and, ultimately, to derive the spillover benefit from those negotiations into their dealings with health plans. As a practical matter, however, ACNM's members are only too aware that the provision offers no real negotiation rights for groups of non-MD providers. CNMs and other non-physicians, who have far less any market power than physicians, would most likely be effectively disregarded or shut out of negotiations with alliances while organized groups of physicians dominate the negotiation process.

Finally, the proposed exemption is unnecessary. To the extent that any state wishes to permit negotiations between alliances and providers, it can craft a statute which would satisfy existing "state action" immunity standards which because they require state government supervision, will also protect consumer interest. Section 1322 (c) should be deleted from the HSA. Any state that wishes to avail itself of state action immunity standards may do so.

S. 1658 and S. 1770. ACNM opposes the antitrust exemptions and immunities which would be created by these bills. These proposed exemptions are far more extensive than either existing antitrust defenses and immunities (which are equally available) to other sectors of the U.S. economy or the Department of Justice/FTC Enforcement Policy Statements. Based upon ACNM's consultation with FTC and DOJ officials and upon observation of the applicability of the Statements in practice over the past several months, ACNM is satisfied that the Enforcement Policy Statements can be refined into a useful tool which will be equally applicable to non-physicians. These Statements will provide sufficient guidance to discourage genuine anti-

trust violations and abuses while permitting procompetitive joint actions by health professionals and other providers.

ACNM is greatly concerned that the provisions of these bills will leave it's members largely defenseless against the anticompetitive practices of dominant provider groups. Nurse-midwives, like many other groups of non-MD health professionals, have indeed looked upon the antitrust laws as the "Magna Carta of our free enterprise system." For many years, CNMs have sought the assistance and protection of the Federal Trade Commission and the federal courts when anticompetitive barriers to nurse-midwifery practice were unjustifiably imposed by hospitals, by groups of physicians, by health insurance plans, or by malpractice insurers. Mary Lou Steptoe, Acting Director of the FTC's Bureau of Competition, cited one such example in her testimony—a boycott of nurse-midwives and the physician who worked with them by a malpractice insurer controlled by the state medical society [*State Volunteer Mutual Insurance Co.*, 103 F.T.C. 1232 (1983)], but many other examples exist. Many other malpractice insurers, similarly controlled by state medical societies or other groups of physicians, routinely impose excessive and unjustified surcharges upon obstetricians who work or consult with nurse-midwives. One such case occurred in the District of Columbia only two years ago.

In addition, nurse-midwives are frequently denied access to clinical privileges to provide their professional services in hospitals, even when the hospital administration affirmatively desires to add CNMs to its staff, because of organized opposition by the hospital's medical staff. The FTC has filed at least one such action to open up a hospital medical staff over physician collusive opposition [*in re Medical Staff of Memorial Medical Center* (File No. 851–0002), 5 Trade Reg. Rep. ¶ 22,508 (January 28, 1988)], and individual nurse-midwives have filed private antitrust actions to overcome organized physician resistance to hospital access by CNMs. One such case, *Nurse-Midwifery Associates* v. *Habet*, 918 F.2d 605 (6th Cir. 1990), held that physician members of medical staff may be held liable for conspiring with each other as independent competitors, to commit an antitrust violation by excluding a competing health professional.

Nurse-midwives today confront numerous other instances of anticompetitive conduct designed to exclude them from competing in the health care market. The preservation of federal antitrust laws is essential to provide remedies for antitrust violations which injure our members' ability to practice and deny consumer's any choice among health professionals. Denial of clinical privileges is widespread. In addition, many health insurance companies or managed care plans, particularly if they are controlled by a physician-dominated provider panel or by the state medical society, routinely refuse to reimburse for CNM services or to permit CNMs to become members of the provider panel of an IPA or PPO. Such exclusion of a competing non-MD provider was held, in *Virginia Academy of Clinical Psychologists* v. *Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), to be a violation of section one of the Sherman Act. Unfortunately, ACNM can provide numerous instances where a managed care plan has refused to include CNMs on it's panel because of physician opposition, with the result that CNM practices have gone out of business while women and infants in the are remain underserved.

ACNM is also concerned about the development of practice guidelines or parameters by physician groups, under the guise of quality of care standard setting, which are really thinly-disguised attempts to limit the scope of nurse-midwifery practice or to discourage physicians, hospitals, or managed care plans from working with CNMs. Anticompetitive standard-setting is not uncommon in health care or other markets. *See. e.g. American Society of Mechanical Engineers C. Hydrolevel Corporation* 456 U.S: 556 (1982) (product quality standards developed by professional society which are used to injure competitor of member violate antitrust laws). Groups of physicians may develop "standards" or "practice parameters" which contrary to state scope of practice laws for CNMs, or clinical indicators, limit particular procedures to physicians or would require physician supervision of CNMs. ACNM is greatly concerned that blanket antitrust exemptions, of the breadth demonstrated in these two bills, will condone and permit such practice barriers and other means of anticompetitive exclusion of nurse-midwives while, at the same time, limiting the range and effectiveness of antitrust remedies available to those whose business or property has been injured by reason of these or other antitrust violations. The FTC and Antitrust Division cannot rectify or monitor all anticompetitive activities. ACNM's members and the consumers they serve would be greatly harmed if the remedy of treble damages lawsuits to vindicate practice restrictions were eliminated or rendered impractical.

Attached to our testimony is a copy of an advertisement opposing antitrust exemptions which appeared in the Wall Street Journal this past week. ACNM, along with several other consumer and provider groups, is a signatory to that advertise-

ment. The American Medical Association has accused the insurance industry of using consumer and non-M.D. provider groups to cloak an anti-physician insurer agenda. ACNM is not a pawn of the insurance industry by any means, and opposes continued antitrust exemption for the insurance industry under the McCarran-Ferguson Act. Antitrust exemptions should play no role whatsoever in health care reform. Rather, to the extent that market forces are being encouraged, through various proposed health reform plans, to lower costs and make insurance accessible to all Americans, antitrust exemptions can only be counterproductive to such goals. ACNM will continue its opposition to all such special interest legislation.

The ACNM has adopted this position because its leadership and members believe that such exemptions are contrary to the spirit and the principles of health care reform, injurious to consumer welfare and, ultimately, unnecessary. We also believe that all anticompetitive activities, whether monopolistic practices by insurers or providers, competitor collusion, or discrimination by physicians, hospitals, and health plans against non-MD health professionals, will ultimately result in restricting optimal delivery of health care services, limiting consumer choice, and injuring those who provide, as well as those who purchase, such services. We urge committee members to consider the important consumer protection and competition values which are at stake in this legislation and to reject any and all antitrust exemptions for health care providers or other participants in the health care industry.

JUST SAY "NO" TO THE A.M.A.

The Honorable Howard M. Metzenbaum
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

As Congress considers health care reform legislation, we are writing to express our opposition to the creation of statutory antitrust exemptions, such as those proposed in the President's "Health Security Act" and in S. 1658/H.R. 3486, the "Health Care Antitrust Improvements Act of 1993". These exemptions would inhibit competition and harm consumers by increasing costs and impeding innovation in health care delivery.

Current antitrust laws are intended to preserve competition and promote consumer welfare. As such, these laws are crucial to achieving two critical goals of health care reform: 1) to provide consumers with affordable, high-quality care and 2) to promote the efficient delivery of services. Expanding antitrust exemptions beyond what current law permits, would only serve to undermine these objectives by insulating collusive activities. Ultimately, the public could bear the brunt of these changes in the form of:

• **HIGHER PRICES**

Antitrust laws prevent price-fixing and the potential boycotting of health plans while promoting competitively priced fees that lower health costs. Last year, FTC Chair Janet D. Steiger testified that "experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and thwart cost reductions."

• **REDUCED QUALITY AND CHOICE**

If physicians are allowed to engage in otherwise prohibited collaborations, they could act to restrict the type and categories of providers available to patients. In addition, sanctioning limited competition among certain providers could reduce their incentive to improve quality of care and service.

• **LESS INNOVATION**

Existing antitrust law provides adequate flexibility for physicians, hospitals and professional groups to work together to organize new networks and other provider delivery systems. More importantly, they help promote innovation by encouraging providers to distinguish themselves in ways that will benefit consumers — for example by competing on the basis of quality as well as cost. New antitrust exemptions would simply halt the competitive incentive for innovation.

While we acknowledge that additional enforcement guidelines may be necessary as the new health system evolves, we also recognize the very real dangers inherent in moving beyond what current law has deemed to be safe, appropriate and necessary. We are thus in complete agreement that changes to existing antitrust laws are simply unnecessary and a real threat to consumer welfare.

Sincerely,

American Association of Retired Persons

American Association of Nurse Anesthetists

American Federation of Home Health Agencies

American College of Nurse Midwives

The Alliance For Managed Competition

American Nurses Association

American Occupational Therapy Association

American Optometric Association

American Speech-Language Hearing Association

Aetna

Consumer Federation of America

The ERISA Industry Committee

Blue Cross & Blue Shield Association

Blue Cross of California

CIGNA Corporation

National Capital PPO

Consumers Union of United States

Federation of American Health Systems

Group Health Association of America

Home Health Services & Staffing Association

Independence Blue Cross

MetLife

National Association of Childbearing Centers

The Principal Financial Group

The Prudential

The Travelers Insurance Companies

U.S. Healthcare

Washington Business Group on Health

STATEMENT OF THE AMERICAN NURSES ASSOCIATION

Hon. DANIEL MOYNIHAN, *Chairman,*
Senate Finance Committee,
Washington, DC.

Dear Mr. Chairman: The American Nurses Association (ANA) is the oldest and largest professional nurses association in the United States. ANA represents over two million nurses through its 53 constituent state and territorial nurses associations. In our role as a professional association and labor organization, we are involved in issues affecting patient care, professional practice, quality assurance and risk management. We are writing to express our opposition to the creation of statutory antitrust exemptions.

ANA firmly believes that a reformed health care system is a priority, and will result in increased access to cost effective, quality health care services. Measures which relax the current antitrust laws have a direct adverse impact on the consumer. Exempting anticompetitive activities by professionals or any other entities from antitrust laws, raises the potential for increased prices and lower quality health care services. This is in direct conflict with the goal of health care reform—universal coverage of and access to affordable, quality, comprehensive health care services.

For these reasons, we are asking you to oppose the provisions in the Health Security Act that permit health providers to negotiate collectively for the fees for their services. Furthermore, we ask you to oppose S. 1658/H.R. 3486, the "Health Care Antitrust Improvement Act of 1993" which would also create sweeping exemptions to existing law and preempt the enforcement of state antitrust laws.

ANA believes that the role of the state and federal governments in antitrust protection is essential and must be maintained. These protections have been established for the protection of the consumer. ANA urges you to delay consideration of any action that would change current antitrust law until after health care reform legislation has been completed.

Sincerely,

VIRGINIA TROTTER BETTS, MSN, JD, RN,
PRESIDENT.

STATEMENT OF ANNE K. BINGAMAN

(VIEWS OF THE DEPARTMENT OF JUSTICE)

I am pleased to have the opportunity to submit to the Committee the views of the Department of Justice on the role of competition and the antitrust laws as significant reform of our health care system is underway. My statement will also address the antitrust-related provisions of the President's proposed Health Security Act.

THE VITAL IMPORTANCE OF COMPETITION AND THE ANTITRUST LAWS

The President's proposed Health Security Act and most of the other major proposals for health care reform rely heavily on the forces of competition to increase the availability and improve the quality of health care services, foster efficiency in the delivery of those services, and control their spiralling costs. For too long, the salutary effects of competition in health care marketplaces have been inhibited. Third party payment mechanisms that do not stimulate cost-effective consumer and provider decisions, limitations on the ability of consumers to choose health care plans on the basis of quality and price, and consumer unawareness of the merits and costs of the choices they do have are examples of inhibitions on competition that need to be addressed.

The Health Security Act promotes competition in many ways. The health care delivery system it will create will stimulate increased competition between and among various types of health plans and between and among institutional and individual health care providers. Plans will compete to be selected by consumers by seeking ways to lower premiums and increase the quality of care through networks of qualified providers. Providers will compete to develop or participate in plans by-demonstrating that they can provide high quality care at affordable prices, and by seeking innovative ways to offer that care. Consumers will have information that will make them better able to evaluate and select their health care coverage on the basis of cost and quality, and thus play their important role in stimulating effective competition among plans and providers. In short, the Health Security Act will promote competition to its rightful status as a major determinant in health care reform.

As we reform our health care system to rely heavily on increased competition, it is vital that we remember that promoting and protecting that competition requires effective prohibitions against private conduct that would undercut it. Fortunately, we do not have to invent such prohibitions: They have existed for a century in the form of our antitrust laws. Given the proposals for sweeping immunities from the antitrust laws or serious constraints on their effectiveness in some of the bills before the Congress, however, I fear that this simple connection between increasing competition and preserving the laws that protect it may be overlooked as health care reform is pursued. That is a mistake we must not make.

The antitrust laws of the United States and their enforcement by the Department and the Federal Trade Commission are sound, including as applied in the health care industry.

The antitrust laws have existed for over a century as the principal guarantor of effective competition in free marketplaces. They have proved, time and again, far superior to pervasive government review, regulation, and oversight of individual or collective activities that may have competitive consequences. Indeed, they have been termed the "Magna Carta" of our fundamental national economic system.

In the health care area, as is the case generally, the antitrust laws are enforced so as to take into account not only indications of possible competitive harm, but also the potential for procompetitive increases in efficiency, lowered administrative and other costs, improvements in quality, enhanced innovation, and other factors that are important to the cost-effective delivery of quality health care services. Many types of procompetitive industry activity are well recognized as highly unlikely to raise any significant competitive concern. For example, neither the Department nor the FTC has ever challenged a joint venture among hospitals to purchase, operate and market high-technology or other expensive medical equipment. Only those activities that would harm health care markets and consumers by raising prices, decreasing availability or quality of services, or discouraging innovation face potential antitrust challenge.

ANTITRUST GUIDANCE TO THE HEALTH CARE COMMUNITY

Although antitrust principles in the health care area are basically sound, the Department and the FTC have recognized that antitrust uncertainty in the health care community, particularly in these changing times, should be addressed. To that end, we have been working since last summer to provide antitrust guidance to the industry. In September 1993, we issued six Statements of Antitrust Enforcement Policy in the Health Care Area, covering matters that we knew to be of concern to health care providers and others. Our statements cover six areas:

- Hospital mergers
- Hospital equipment joint ventures
- Physicians' provision of information to purchasers
- Hospitals' exchange of price and cost data
- Joint purchasing arrangements among providers, and
- Physician network joint ventures.

Our statements contain "safety zones" describing mergers, joint ventures, and other activities that the agencies have concluded are very unlikely to raise competitive concerns. The statements also make clear, however, that conduct that does not fall within the safety zones is not by implication likely to be challenged by the Department or the FTC. Indeed, much conduct not amenable to coverage by a safety zone because of the significance of the particular circumstances will be recognizably and demonstrably procompetitive in those circumstances. The statements set out the analysis the agencies use in evaluating conduct outside the safety zones so that health care providers may more confidently assess antitrust issues raised by proposed conduct even if the safety zones themselves are not applicable.

Both the safety zones and the agencies' analysis of other conduct are set out in our policy statements in simple, straightforward terms. Our goal is to provide antitrust guidance to health care providers themselves, and not only to the antitrust bar that advises the industry.

While our 1993 policy statements cover a lot of ground and, I believe, have contributed greatly to health care providers' understanding of antitrust issues, I also believe that we can and should do more. When we issued our policy statements last September, we recognized that additional antitrust guidance in the areas they cover as well as in other health care areas may be desirable. We are hard at work on such additional guidance right now, and have pledged to continue this effort. In this regard, I want to express my sincere appreciation for the advice and counsel we have received from representatives of the health care community in our ongoing efforts to develop useful antitrust enforcement policy statements. The legal and practical

insights that have been shared with us by the American Hospital Association, the American Medical Association, and a variety of other interested and knowledgeable parties have been invaluable.

We have also instituted an expedited procedure to supplement the general antitrust guidance set forth in the Statements of Antitrust Enforcement Policy in the Health Care Area with more specific guidance on specific proposed conduct. We have committed to respond to requests for Department business reviews of specific health care activities within 90 or 120 days, depending on the nature of the conduct. The Federal Trade Commission has made the same commitment with respect to its advisory opinion procedure. Health care providers are taking advantage of these procedures, and we anticipate that they will result in significant further clarification of antitrust rules and guideposts to the advantage of all.

ANTITRUST PROVISIONS IN THE HEALTH SECURITY ACT

The Health Security Act contains two antitrust-related provisions. First, section 5501 of the Act repeals the broad antitrust immunity in the McCarran-Ferguson Act for the business of insurance to the extent that such business relates to the provision of health benefits. The current, broad immunity could allow health insurers to act anticompetitively and thereby interfere with the Health Security Act's goal of relying on competition between insurers to control health care costs.

The Health Security Act also provides that, in connection with the establishment by a regional alliance of a fee schedule for use in regional alliance fee-for-service health plans, health care providers may collectively negotiate the fee schedule with the regional alliance (section 1322(c)). This section recognizes that the establishment of such fee schedules by the alliances is basically a governmental function under the Act, and provides that the actions of the alliances in this regard and their negotiations with providers collectively shall be accorded the antitrust treatment due to government actions and efforts by private parties to influence those actions (section 1322(c)(5)). Such actions and efforts generally are not subject to the antitrust laws, but under section 1322, as is the case generally, there are important limits on what actions providers may take to influence an alliance's fee-for-service schedule decisions. The principal limitation is that providers may not threaten or engage in any boycott to force an alliance to adopt their suggestions or recommendations (section 1322(c)(6)). As used in section 1322, the term "boycott" is intended to include any threat or action through which providers collectively would decline initially to participate, or deparcticipate, in fee-for-service health care delivery unless fees were set at certain levels.

Before concluding, I would like to underscore the one point I think is vital to keep in mind as antitrust issues are considered during health care reform. Among the primary goals of such reform is to bring the forces of competition effectively to bear in health care markets as never before. To accomplish this goal the efficacy of the antitrust laws must be preserved, and we seek the Committee's support in this effort. The Department of Justice must also continue to work with the FTC and the health care community to reduce unwarranted antitrust uncertainty in the health care area, which we have pledged to do.

Thank you again for the opportunity to submit to the Committee the views of the Department of Justice on these important issues.

PREPARED STATEMENT OF WILLIAM C. BRYSON

I am pleased to submit this testimony regarding the Health Security Act and the Administration's proposals relating to medical malpractice reform. The President is grateful for the priority you have given this legislation. Every member of this Administration stands ready and willing to assist you and your colleagues, so that we may realize the prompt enactment of this historic proposal by the Congress.

The President's health care reform plan is the most detailed and comprehensive health care reform proposal ever offered. As with other parts of the plan, the President has committed his views to legislation, and my testimony is part of a continuing dialogue on those views.

There are many things wrong with the medical malpractice system as we know it today. Some who are injured are perceived to be overcompensated; others are undercompensated or shut out of the system altogether. There is little empirical evidence that the malpractice system deters substandard care or promotes the practice of quality medicine. We all know that the civil litigation system can be inefficient and expensive. We know that doctors practice defensive medicine which, at least in part, is related to malpractice litigation. While the costs may be hard to quantify,

we do know that such practices have contributed to the soaring costs of our national health care bill.

The President's proposal attempts to address the problems with the current malpractice system, while recognizing that medical malpractice litigation is a fundamental aspect of basic state tort law and jurisprudence. We know that virtually every state has adopted specific malpractice reforms since the malpractice liability insurance crises of the 1970's and 1980's. Each of those reforms has been tailored to the unique circumstances of the respective state court and civil justice system involved. We strongly believe that medical malpractice cases should continue to be litigated primarily in the state courts and that medical malpractice reform should respect the fundamental nature of state practice and procedure.

Before I describe the specific reforms contained in the Health Security Act, I want to refer to the conclusions of several of the best studies of medical malpractice. Some of these are probably familiar to you, but they are worth repeating. However, one of the frustrations about this whole issue is the lack of good empirical data to guide our deliberations. For a problem of this importance, the scarcity of reliable research data is astonishing. I am hopeful that we might address the need for top-quality empirical research through this legislation and an increased emphasis on federal funding for such research.

The Harvard Medical Practice Study of hospital discharges in New York in the mid-1980's found that 3.7% of all people discharged from the hospital suffered adverse medical events. Over 25% of those, or 1% of discharges overall, were due to provider negligence.

Only one out of eight patients injured as a result of negligence filed a malpractice claim, and only one out of sixteen received any compensation from the tort system.

In New York, the average delay between initial claim and eventual payment was six years, and over ten years for the more serious injuries.

A different study found that many injured parties are frequently undercompensated, particularly those suffering permanent, serious injuries. Because payment typically comes so long after injury, funds for early rehabilitation are not available.

For every patient who does not receive fair compensation, there is a doctor who feels financially threatened by potential lawsuits, the unpredictability of jury verdicts, and high liability insurance premiums. In one major study, over 80% of patients who filed suits had not in fact been negligently injured. Physicians view the malpractice system as haphazard, unpredictable, and personally traumatic, exposing them to the attendant costs and delays of our troubled civil justice system.

Striking the proper balance of competing concerns in this environment is not an easy task. There is no simple solution. There are strongly held views on all sides, and some truth on all sides.

The President's proposal provides two new mechanisms for a more sensible and cost-effective approach to resolving medical malpractice disputes. First, it encourages consumers and providers to settle malpractice claims outside of court. Every health plan will be required to develop and have in place at least one alternative dispute resolution mechanism, and every claim against a doctor or other provider must first be referred for alternative dispute resolution before it can be litigated.

While ADR is not binding, meaning that consumers dissatisfied with the outcome can go to court, it is mandatory. Attempting to settle malpractice claims before they get to court has rewards for both patients and providers. Parties suffering real injuries will be compensated sooner and claimants with smaller claims will have increased access to a dispute resolution mechanism. The plan administrators will be aware of those providers with a track record of claims against them, and physicians may be spared the expense and distraction of defending groundless claims.

Second, the Health Security Act provides that the National Practitioner Data Bank will make available to the public the names of practitioners who have a pattern of malpractice payouts or sanctions. Under the Health Care Quality Improvement Act, malpractice payouts and sanctions are reported to the National Practitioner Data Bank and are made available to states or accrediting bodies, but not to the general public.

For the first time, the names of licensed health care practitioners with repeated numbers of malpractice payments or sanctions will be available to the public. Combined with the quality measures in the proposal, the public can make more informed choices about the practitioners they choose. With adequate information, consumers can improve the quality of the health care they receive by their choice of practitioners.

The Health Security Act also contains certain proposed reforms to discourage the filing of frivolous lawsuits and to provide fair, uniform national rules for malpractice awards.

First, the proposed Act limits the amount of a lawyer's fee to no more than one-third of the amount recovered in a malpractice case. However, states may impose lower limits. While some have challenged this proposal as unfair to plaintiffs' trial lawyers, it is a change which has already been implemented in some form in the majority of states. In fact, the Federal Tort-Claims Act, under which medical malpractice suits are brought against federally-employed health care providers, establishes even lower attorneys' fee limits.

Second, under the Administration's proposal, before a lawyer can file a medical malpractice lawsuit, he or she has to first consult a qualified medical specialist, and prepare an affidavit including a written report by the medical specialist. The written report must contain the specialist's determination that the specialist has reviewed the medical records, and believes there is a "reasonable and meritorious" claim. Courts can impose sanctions against a plaintiff or attorney for affidavits submitted without reasonable cause.

Third, double recoveries are eliminated by abolishing the collateral source rule in both federal and state medical malpractice cases. The proposal reduces the amount of recovery by any amount recovered from another source, such as private disability insurance. Again, this is simple fairness. If a health plan already provides for the health coverage needed by an injured patient, there is no reason that a malpractice award should include this amount.

Fourth, the proposal allows either party to request that an award be paid periodically rather than in a lump sum. The judge would determine the schedule based on the needs of the injured party'. This proposal, which is consistent with the recommendations of the National Conference of Commissioners on Uniform State Laws, is important for both injured parties and defendants so that damages will compensate people at the time they need the money.

Over the past months, we have examined many different options. I know that distinguished Members of the Committee may have different ways of addressing the same problems we have identified. We hope to discuss how best to accomplish our common goal.

One of the issues that has been debated is consideration of caps on damages in malpractice cases. Many urge that a limit be placed on non-economic damages, such as pain and suffering.

We have examined that issue in detail, and heard every opinion. It was decided not to recommend caps on damages, and let me explain briefly why that decision was made. First, we have designed a series of changes intended to address specific problems with the malpractice system. If we address the problems of frivolous lawsuits and the lack of effective quality measures, and if we place limits on double recoveries, there is no reason to place arbitrary limits on damages.

Second, as I mentioned earlier, studies have shown, and it is obvious, that those affected by caps on damages are those most severely injured who are likely to get large awards. It is those same individuals who need the money to allow them to get on with their lives. No one wants to tell persons who have been severely injured through the negligence of others that they will not get compensation because there is an arbitrary limit, and that they are simply out of luck.

Third, the states have enacted various limits on damages, and a few states have even held a cap on damages to be unconstitutional under their respective state Constitutions. It would disrupt those state initiatives to impose limits at the federal level. The state limits vary widely. For example, California has a cap on non-economic damages of $250,000; Indiana has an overall limit of $750,000 for all damages.

The Health Security Act attempts to strike a balance between the needs of those who are injured and those working diligently to provide high quality health care. We believe we have done that. We recognize that this is a controversial area, with strongly held views on all sides.

Let me also add that the problems of the medical malpractice system are exemplary of the many difficulties confronting our civil justice system at both the state and federal levels. The Justice Department has undertaken a major access to justice study, aimed at reducing the costs and delays of civil litigation, increasing access to our justice system for all litigants, and restoring public confidence in a system which is fundamental to our concepts of law and liberty. I am hopeful that we will soon formulate proposals that will address the problems inherent in medical malpractice and other kinds of civil litigation.

I appreciate the opportunity to discuss our views and I look forward to working with all of the Members of this Committee in the months ahead as we move forward in our historic effort to guarantee health security for all Americans.

ABSTRACT

Objective: This report addresses the need for annual clinical preventive services for 11- to 21-year-olds and provides cost estimates for those services under fee-for-service and capitated health care payment systems. Preventive services include screening, health promotion, and immunizations.

Design: The prevalence of adolescent morbidities was derived from national surveys. Estimated costs of these morbidities were obtained from published data and adjusted for 1992 dollars using the Consumer Price Index. The estimated costs of preventive services for adolescents under a fee-for-service system were derived from a 1993 survey of nine Blue Cross/Blue Shield plans and four insurance companies. The estimated 1992 costs of preventive services under a capitated system were obtained from eight prepaid health groups with over 50,000 members, and from a large West coast prepaid group plan.

Main Outcome Measures: The cost of adolescent morbidities includes only direct medical costs for a single year, and excludes long term and indirect costs. The cost of clinical preventive services is calculated at 100%, 75% and 50% participation levels.

Results: Each year an estimated $34.4 billion is spent on select adolescent morbidities, approximately $855 per adolescent per year. The cost of clinical preventive services for adolescents ranges from $57 to $130 per adolescent per year in a fee-for-service system and from $72 to $172 in a capitated system.

Conclusions: The cost-effectiveness of clinical interventions on various health risk behaviors is unknown but the costs of prevention represent an affordable alternative to the current costs of adolescent morbidities.

INTRODUCTION

The emphasis on preventive care in several health care reform proposals in the United States[1,2] is especially appropriate for adolescents. Most serious adolescent health problems---suicide and depression, unintended pregnancy, sexually transmitted diseases, motor vehicle injuries, intentional injury and abuse, and use of tobacco, alcohol, and drugs---have become so prevalent that health care providers and policy makers have increasingly called for a shift toward prevention (which promotes environmental and behavioral changes as a means to improve health), rather than relying primarily on treatment or rehabilitation of existing problems.[3,4]

In December, 1992, the American Medical Association released a set of 24 recommendations which address the preventive health care needs of adolescents, known as the Guidelines for Adolescent Preventive Services (GAPS) (see Figure 1).[5] GAPS recommends a comprehensive set of preventive services for adolescents between 11 and 21 years of age. The GAPS model of preventive services is based on the existing model of a series of routine, well-child visits from birth through five years of age. During a preventive services visit, primary care physicians would screen adolescents for select health problems and provide appropriate health guidance and immunizations. Because the initiation of health risk behaviors usually occurs during early and middle adolescence, GAPS recommends that adolescents be seen at least annually until it is clear to the provider that their developmental trajectory is one of low behavioral risk. Between 11 and 21 years of age, three physical examinations are recommended unless symptoms or health conditions are identified which

warrant more frequent examinations. GAPS explicitly recognizes the critical role parents have in influencing behavior among adolescents and recommends that physicians meet with parents at least once during their child's early adolescence and once during middle adolescence. During this visit the provider would offer health guidance about normal adolescent development, signs and symptoms of disease and emotional distress, and parenting behaviors that promote healthy adjustment and avoid potentially harmful behavior.

GAPS recommendations promote a comprehensive strategy rather than targeted prevention activities which focus on one or a more limited array of health problems. The conditions addressed by GAPS were selected based on the severity of the burden of suffering they impose on adolescents. The specific recommendations were shaped by advice and review from a multidisciplinary group of national experts. A complete description of how GAPS recommendations were developed and the scientific rationale for each recommendation can be found elsewhere.[6]

Empirical research on adult patients has shown that physicians can effectively deliver preventive interventions that are aimed at changing patient behavior. A meta-analysis of 54 studies which evaluated patient education and counseling for smoking cessation, nutrition, weight loss/management, injury prevention, and other health behaviors found that physician intervention can have a significant impact on behavioral change among experimental groups.[7] The INSURE project (Industry-wide Network for Social Urban and Rural Efforts), which assigned patients to experimental and control groups, also identified several areas of improved health behavior among adult patients in a preventive services program, compared to patients in the control group.[8]

Measuring the effect of clinical preventive services on *adolescents*, especially those directed at behavioral change, is difficult and results are inconclusive. Prevention procedures such as immunizations are highly effective in reducing disease, but the efficacy of health guidance with adolescents on behaviors such as a healthy diet, adequate exercise, and abstinence from involvement in behaviors such as sexual intercourse and tobacco and alcohol use, is much less certain. Research data clearly show that primary health providers are able to identify adolescents who are involved in health risk behaviors. Whether interventions to change these behaviors are effective with adolescents, however, is less well-studied. Nevertheless, primary care providers have an obligation to identify adolescents involved in these behaviors and to intervene themselves or refer the adolescent elsewhere for more intensive management.

The expansion of coverage for adolescent preventive services in proposed basic health care plans raises several important policy questions about the costs and benefits of these services. These questions include: 1) How prevalent are adolescent health problems and what are the current costs of these problems? 2) How do these costs compare with the estimated costs of providing preventive services for adolescents? 3) How much would GAPS services add to the costs of existing insurance premiums in a fee-for-service system, and what would be the likely costs of care in a capitated or "prepaid insurance" system?

This paper addresses each of these questions. The first section describes the incidence and prevalence of select adolescent health problems, as well as the medical costs associated with them for a single year. The second section estimates the medical costs of providing GAPS recommendations in a fee-for-service payment system. The third section of the report

provides estimates of premiums that insurers would charge for implementing GAPS recommendations under a capitated payment system. The paper concludes with a discussion of the role of clinical preventive services in helping to improve adolescent health.

INCIDENCE, PREVALENCE, AND MEDICAL COSTS OF TREATING ADOLESCENT HEALTH PROBLEMS

During the past 20 years increasing numbers of adolescents have started experimenting with health risk behaviors at younger ages.[9] For many adolescents, this experimentation happens in a short period of time. As shown in Figure 2, among 11-year-olds nearly one in five has smoked a cigarette, one in ten has consumed alcohol, and three in 100 have smoked marijuana.[10] More than half of adolescents have tried alcohol before their 14th birthday,[10] more than half have tried cigarettes before their 15th birthday,[10] more than half have had sexual intercourse before their 17th birthday,[11,12] and nearly half have tried marijuana by the time they are 19.[10,13]

Some adolescents who experiment with health risk activities stop before they become heavily involved in them or suffer serious health consequences. Others incorporate potentially health-damaging behaviors into their lifestyles. As shown in Figure 3, one in three 9th through 12th grade students smoke cigarettes fairly regularly, and nearly six in ten consumed alcohol in the past month.[14,15] Among 1990 high school seniors, one in four report driving after drinking alcohol and one in three report riding in a car with a driver who had been drinking[16]---clear risks for injury or death from motor vehicle crashes. More than one in three of all 9th through 12th grade students report having sex in the past three months and nearly one in five report having sex with four or more partners in their lifetime;[17] known risk

factors for unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection (HIV). More than one in four 9th- through 12th-grade students report having seriously considered suicide.[18] Each year hundreds of thousands of adolescents experience serious consequences from involvement in the health-threatening behavior. Figure 4 shows the incidence of select adolescent morbidities.[18-24]

Comprehensive clinical preventive services have four goals: 1) to deter adolescents from participating in health-threatening activities, 2) to increase early detection and intervention in physical, emotional, and behavioral problems, 3) to reinforce and encourage health-promoting behaviors, and 4) to provide immunizations against infectious diseases. If achieved, these goals should substantially reduce the costs of adolescent health care.

To gauge the impact on U.S. health care costs of increased use of the adolescent preventive services proposed by GAPS, the total medical costs of treating select, *preventable* adolescent health problems are estimated for a single year. These costs are then compared with the estimated costs of providing annual preventive services to the entire 11- to 21-year-old population. In the analyses that follow, health care delivery costs are separated from economic, legal, and other social costs associated with a medical condition (except for alcohol-related motor vehicle injuries). This approach substantially underestimates real economic costs of adolescent morbidities, but it makes it possible to gauge the economic impact of preventive services on the health care system.

An estimate of the total annual medical costs currently spent on select adolescent health problems appears in Figure 5. These conditions were chosen because they are included in the GAPS recommendations and because prevalence and cost data were available.

Whenever possible, the most recent statistics on prevalence were used; most data are from 1990. All cost estimates are presented in the dollar amount for the year in which cost data were available and then converted to 1992 dollars using the multiplication factors that appear in the Consumer Price Index for Medical Care Services.[25]

Adolescent Pregnancy: Adolescent pregnancy is divided into three different types of costs: therapeutic abortion, hospital costs for treating low birth weight infants, and hospital and physician charges for live births. (Miscarriages are not included because their prevalence and associated costs are unknown.) In 1988, the most recent year for which statistics are available, there were 392,720 abortions among 15- to 19-year-olds.[26] Eighty-three percent of abortions were performed during first trimester (n= 326,743), and 17% during the second or third trimester (n= 65,977).[27] In 1989, the average cost of a non-hospital first trimester abortion was $309, while the cost of an abortion performed later in gestation was $544.[28] Thus, the total cost of abortions among 15- to 19-year olds was ($309 x 326,743) + ($544 x 65,977) or $136,855,075. The cost in 1992 dollars would be $172,847,960.

Hospital costs for treating low birth weight infants are included in these estimates because they are pregnancy-related costs that often result from delayed or inadequate prenatal care.[29,30] In 1989 there were 517,989 births to women under the age of 20 years.[31] Of these, 9% or 46,619 were low-birth-weight infants.[32] Average hospital costs range from $11,670 to $39,420 per low-birth-weight infant.[33] Therefore, the hospital costs for low-birth-weight infants of adolescent mothers ranged from $544 million to $1.8 billion (or an average of 1.172 million). The cost in 1992 dollars would be approximately $1.5 billion.

Hospital and physician costs for live births to mothers 15 to 19 years of age were

calculated as follows: In 1989 the cost of a normal birth was $4,334 and the cost of a caesarean section was $7,186.[34] In 1989 there were 517,989 births to adolescents under 20 years of age[31], and 16% of births to adolescent women under the age of 20 were delivered by caesarean section.[35] Therefore, total annual obstetrical costs are (82,878 x $7,186) + (435,111 x $4,334) = $2,481,332,382. The cost in 1992 dollars would be $3,133,922,798.

Sexually Transmitted Diseases (STDs): Data on the prevalence of sexually transmitted diseases among 15- to 19-year-old adolescents in 1990 were provided by Kathleen Toomey, MD of the Centers for Disease Control and Prevention (CDC). According to the CDC, there were 16,000 reported cases of syphilis among 15- to 19-year-olds, 410,000 cases of gonorrhea, an estimated 940,000 cases of chlamydia, 200,000 cases of pelvic inflammatory disease (PID), 1,270,000 cases of genital herpes simplex virus (HSV) infection, and 1 million cases of human papillomavirus (HPV) infection. Based upon these figures, there are approximately 3.8 million cases of STDs among adolescents each year. The number of adolescents who have STDs which are diagnosed and treated, however, is unknown.

The annual medical costs for the STDs listed above were computed based on outpatient treatment only. This included the cost of the office visit (i.e., physician time), laboratory tests, and medications. Except for the treatment of HPV, which was estimated to require five clinic visits, each case of STD was assumed to be associated with one office visit. Office visits were estimated at an average of $50 per visit across all cases of STDs, while the average cost of laboratory tests was estimated at $30 per case. Among 15- to 19-year-olds, the total cost of drugs for treating specific STDs (excluding physician time and laboratory tests) was estimated at $144,000 for cases of syphilis, $4,198,400 for gonorrhea,

$7,2825,000 for chlamydia, $81,430,200 for PID, $63,500,000 for HSV, and $175,000,000 for HPV. Using the criteria provided above, the total estimated annual cost for physician time, laboratory tests, and medications to treat adolescent STDs was $763,000,000. The cost in 1992 dollars would be $882,028,000.

Treatment for AIDS and HIV Infection: The average inpatient and outpatient cost for treating people with AIDS during the 1991 calendar year was $38,300.[36] In 1992 there were 912 adolescents with reported cases of AIDS[37] (912 x $38,300 = $34,929,600). During the 1991 calendar year the average inpatient and outpatient cost for treating people who were HIV positive but did not have AIDS was $10,000.[36] Between October 1991 and September 1992 there were an estimated 11,400 adolescents between 16 and 21 years of age who were HIV positive. (This is based on the 1:8 ratio of persons with AIDS to persons who are HIV positive, used by the Centers for Disease Control and Prevention.) If each of these 11,400 adolescents received care, then the 1991 costs of treating HIV-infected adolescents without AIDS was 11,400 x $10,000 or $114,000,000. Therefore, the total costs of treating adolescents who were HIV positive or who had AIDS in 1991 was approximately $149,000,000, or $159,579,000 in 1992 dollars.

Alcohol and Drug Treatment. Approximately $185 million was spent in 1987 on adolescent alcohol and drug treatment services---$65 million on alcohol treatment and $120 million on drug treatment, according to unpublished estimates.[38] This includes both inpatient and outpatient treatment, though most adolescents who receive alcohol or drug treatment are seen in outpatient settings (88% and 67%, respectively). This would be approximately $271,395,000 in 1992 dollars.

Motor Vehicle Injuries. Cost estimates for motor vehicle injuries only include crashes involving alcohol, because these are considered to be most amenable to preventive interventions. According to unpublished estimates prepared in December 1992 by T Miller and L Blincoe of the Urban Institute, in 1990 the total cost of minor, serious, and fatal crash injuries among 10 to 21 year old youth was $11.3 billion (or $13,062,800,000 in 1992 dollars). This cost includes medical and ancillary payments, emergency services, and associated non-medical expenses. This is the only estimate that includes non-medical costs.

Unintentional Injuries. Unintentional injury data include direct, first year costs associated with falls, firearms, poisoning, fires and burns, drowning and near drowning, and other unintentional injuries among 15- to 24-year-olds in 1985.[39] Direct cost is defined as "the actual dollar expenditures related to illness or injury, including amounts spent for hospital and nursing home care, physician and other medical professional services, drugs and appliances, and rehabilitation."[39, p.249] In 1985 the per person first year direct costs of injury due to falls was $1,197, for firearms $812, for poisoning $1,007, for fires and burns $631, for drowning and near drowning was $2,466, and for other injuries was $399. During 1985 there were 1,825,000 15- to 24-year-olds who were injured during falls, 60,000 by firearms, 137,000 by poisoning, 370,000 by fires and burns, 2,000 by drowning, and 8,592,000 by other causes. So, the direct first year 1985 costs of injury for this population was $2.2 billion for falls, $231 million for firearms, $138 million for poisoning, $233 million for fires and burns, $5 million for drowning, and $3.4 billion for other causes, for a total of $6.2 billion. In 1992 dollars this would be approximately $10,378,800,000.

Mental Health Treatment. According to the Office of Technology Assessment, an

estimated $2.5 billion was spent in 1986 on non-residential mental health treatment services for youth 10 to 18 years of age.[40] This figure includes only the direct cost for medical treatment. Over 60% of these costs---approximately $1,592 million---was spent on inpatient treatment, while the remainder was used for ambulatory mental health treatment, including hospital outpatient programs, free standing clinics, and other specialty mental health programs. This is approximately $3,885,000,000 in 1992 dollars.

In summary, the total annual medical costs of treating preventable adolescent health problems can be conservatively estimated at $33.4 billion a year in 1992 dollars. For the 39 million youth between 11 and 21 years of age in the United States, the cost associated with treating preventable conditions is approximately $855 per adolescent per year. In the following section this cost is compared to the total costs of offering adolescents an annual preventive services visit.

COST OF PROVIDING PREVENTIVE MEDICAL SERVICES TO ADOLESCENTS

As mentioned earlier, GAPS recommends an annual preventive visit for adolescents between 11 and 21 years of age. As shown in Table 1, the content of these visits varies by age and risk category of the adolescent. The timing of screening tests and immunizations recommended by GAPS, and the estimated percentage of adolescents who would need them at each year of age during adolescence are also shown in Table 1.

For the purpose of this analysis, it is assumed that all 11-year-olds would receive a measles, mumps, and rubella (MMR) vaccine, a tuberculin skin test, and the three-step hepatitis B vaccine. During middle adolescence, all adolescents would receive a tetanus-diphtheria vaccine. Adolescents at high risk of hyperlipidemia (estimated at 50%) would

have a cholesterol screening test during middle adolescence, while those who are not at high risk would be screened during late adolescence. The Centers for Disease Control and Prevention and the American Academy of Pediatrics recently issued guidelines recommending a second MMR vaccine and three hepatitis B vaccines for young children.[41,42] Until these vaccines have been administered to all adolescents, young adolescents should receive a MMR vaccine and the three hepatitis B vaccines.

GAPS recommends annual screening for sexually transmitted diseases among sexually active adolescents. Sexually active adolescent males would receive a leukocyte esterase test, while sexually active females would receive an annual Pap smear and be tested for genital chlamydia and gonorrhea. An estimated 25% of 13-year-old males are sexually active;[37] this percentage increases to 95% among 21-year-old males.[43] An estimated 7% of 13-year-old females are sexually active,[43,44] and this percentage increases to 88% among 21-year-old females.[45] An estimated 20% of sexually active adolescents in 9th through 12th grade are at high risk for HIV and syphilis[17] (having had four or more sexual partners in their lifetime), and would be tested annually for these STDs.

The length of a GAPS preventive service visit will vary depending on whether a physical examination is performed and whether parents are seen as part of the visit. The working assumption is that a routine visit will last about 30 minutes, while an extended preventive services visit will last 45 minutes.

The fees paid by insurance companies to physicians for each specific screening test and immunization recommended by GAPS, along with the Current Procedure and Terminology (CPT) code are shown in Table 2. These fees reflect results from a survey

conducted in 1993 for the National Coordinating Committee on Clinical Preventive Services (of the Public Health Service) by the Actuarial Research Corporation. Nine Blue Cross and Blue Shield Plans and four insurance companies were contacted and asked to report the 1992 maximum payment allowed or the average payment for specific CPT codes for cholesterol screening, HIV testing, Pap smear, screening for syphilis, gonorrhea, chlamydia, and for the following vaccines: HBV, Td, and MMR. The insurance companies were not surveyed on the same CPT codes so there are between seven and thirteen responses for each of these CPT codes. This survey was supplemented by contacts with two insurance companies which were asked to report their fees for leukocyte esterase and tuberculin skin test which were not included in the earlier survey. These estimates reflect 1992 fees within indemnity-type, fee-for-service systems. Geographic variation was taken into account by including responses from all census regions. The exact number of persons covered by these plans is unknown, but all responding companies are major insurers. These estimates represent the unweighted average of fee-for-service payment levels reported by insurance companies for each test and vaccine. (The responses were not weighted by enrollment or region because the number of respondents in each region is too small and may not be representative of the region.) Because comprehensive national data sources on fees are not available, the average payment levels from the surveys were used to estimate 1992 provider fees in the United States.

The price of laboratory tests and vaccines shown in Table 3 include only minimal administrative costs. These prices are between 25% and 68% of the fees paid by insurance companies. The price of vaccines reflects the average catalogue prices charged to private physicians by pharmaceutical companies, and includes a modest administrative surcharge.

These prices, in general, are similar to the prices of tests in health plans with on-site laboratory facilities.

Based on the above calculations, and assuming 100% participation of youth between 11 and 21 years of age, the total estimated payments to physicians under a fee-for-service system for all of the preventive services recommended by GAPS would be $5.1 billion in 1992 dollars (see Table 4). Most of the payments are for routine services (i.e., $4.0 billion for physician fees, vaccines, and cholesterol screening for those not at risk). The other $1.1 billion is for payments for services for sexually active adolescents and adolescents at high risk for HIV infection and syphilis. For the 39 million youth in this age category, the annual payment to physicians per adolescent for GAPS services would be approximately $130. This rate, however, varies depending on the adolescent's age and sex. The annual payment to physicians for treating 11-year-olds is estimated at $304, the highest of any adolescent age group, because it includes the recommended series of vaccines. The payment to physicians per adolescent female ($146) is higher than it is for adolescent males ($115), even though a smaller percentage of adolescent females are sexually active and at high risk for HIV and syphilis. This is because the expenses associated with screening females for cervical cancer and STDs are greater.

If the lower payments for laboratory tests and vaccines described earlier were used (e.g., costs with minimal administrative mark-up), the overall annual payment by insurance companies to physicians would be $108 per adolescent, or $100 per adolescent male and $115 per adolescent female (see Table 5).

Although GAPS calls for annual preventive services for all adolescents, it is unlikely

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that every adolescent will receive such services every year. According to the 1988 National Health Interview Survey on Child Health, 50% of 8- to 11-year-olds, 55% of 12- to 14-year-olds, and 54% of 15- to 17-year-olds visited a doctor for routine care (check-ups and immunizations) during the previous 12 months.[46] These percentages may increase as greater emphasis is placed on preventive care but, because future participation levels are unknown, the estimated costs of preventive services used here are calculated at participation rates of 75% and 50%.

Premiums that insurance companies would charge for coverage of preventive services in fee-for-service plans include payments for physician time, clinical services (including screening tests and immunizations), and administrative charges, at anticipated participation levels. (Administrative charges are estimated at 12.5% for all health plans, though administrative charges for large groups with more than 5,000 enrollees may be as low as 3%).[47] According to the March, 1990 Current Population Survey there are an average of 0.496 adolescents per family insured (including families without children).

If 50% of adolescents received GAPS services at the 1992 average fee paid by insurers, the estimated 1992 premium for covering GAPS services would be $73 per adolescent and $36 per family (see Table 6). Under an assumption of a minimal mark-up for laboratory tests and vaccines, the 1992 premium at a 50% participation rate would be even lower, $57 per adolescent and $28 per family.

At a 75% participation rate, the estimated premium would be $110 per adolescent and $54 per family. The 1992 premium at a 75% participation rate under an assumption of a minimal mark-up for laboratory tests and vaccines would be $91 per adolescent and $45 per

family.

The average health care premiums for employer-sponsored plans in a survey by the Health Insurance Association of America was $4,212 for family coverage in 1991.[48] The GAPS premium at 75% would add only 1.2% to the 1992 total family premium (estimated by adding 10% to the 1991 premium). The additional premium for GAPs would be even smaller for the health plans that already cover at least some of the services recommended by GAPS.

It is worth noting that in a fee-for-service system the cost of the adolescent preventive services described in GAPS is higher than estimates for preventive services recommended by the U.S. Preventive Services Task Force.[49] According to the National Coordinating Committee on Clinical Preventive Services the total cost per year of preventive services recommended by the USPSTF for 0- to 19-year-olds would range from $55 to $59.[49] The costs are lower because GAPS recommends some services that were not recommended by the USPSTF, i.e., the MMR and HBV vaccinations, STD screening for sexually active male and female adolescents, and cholesterol screening and other tests for high risk adolescents. In addition, GAPS recommends an annual visit while the USPSTF recommends a visit every two to three years. These differences, of course, have financial implications.

COSTS OF ADOLESCENT PREVENTIVE SERVICES IN CAPITATED SYSTEMS

The estimates presented thus far reflect estimated charges for adolescent preventive services under a fee-for-service payment system. However, as increasing numbers of people enroll in capitated systems it is important to consider what the estimated costs of these services might be under this payment system. Currently, 30% of the insured population are

enrolled in capitated payment systems.[50]

The common assumption is that the costs of care in a fee-for-service system will be greater than the costs of care in a capitated or "prepaid insurance" system, due in part to lower charges for laboratory tests and physician time, and fewer admissions to the hospital. However, it is difficult to compare directly the costs of preventive services in fee-for-service and capitated systems. There are no data in either payment system that reflect solely the costs of preventive services, and in neither system are the charges for physician time, laboratory tests, and costs of immunizations listed as separate line items. Until better data become available, conclusions about relative costs of preventive care in either payment system must remain tentative.

Based on data compiled from eight prepaid health groups with over 50,000 members, and from a large West coast prepaid group of more than 600 physicians, the range of outpatient capitation ranges from a low of $72 to $84 per adolescent per year, to a high of $172 per adolescent per year. These capitation fees would cover provider fees, education material, and, in some cases, laboratory and immunization costs. This estimate includes costs of all primary care outpatient services, not just preventive services. On the west coast, among larger HMO groups, the average capitation charge ranges from $72 to $120 per adolescent per year, and covers 80% to 130% of usual and customary billing.

Overall, it appears that the costs of providing clinical preventive services to adolescents would be somewhat lower in a capitated system than in a fee-for-service system, though the differences are likely to be small. The costs per adolescent in a fee-for-service would range from $73 to $110 per adolescent per year and from $72 to $172 per adolescent

per year in a capitated system. However, these estimates reflect different services; the fee-for-service estimates include only charges for preventive services while the charges in a capitated system include all primary care.

CONCLUSIONS

The number of adolescents affected by serious health problems is evidence that our current prevention efforts are inadequate; something more needs to be done. The $33.4 billion dollars spent each year to treat these select health conditions tells only part of the story. Many conditions exact substantial financial costs in subsequent years, and many impose both economic and non-economic costs on society whether for medical treatment, social services, or other non-economic costs entailed in lost opportunities and productivity. The suffering these conditions impose on individuals also imposes real (if non-economic) costs. Other interventions must be tried.

Are clinical preventive services for adolescents the answer? There is initial evidence that clinical preventive services can help to improve adolescent health, even though conclusive data on the efficacy of preventive interventions is limited, particularly for many health conditions related to individual behavior. In the 1988 unpublished final report of the INSURE project, a 37% decline in cigarette smoking among adults enrolled in a preventive services program was reported. In addition, the INSURE program showed substanially higher rates of cigarette smoking and alcohol use among adolescents in the control group compared to those in the experimental group. At this point in time one can only speculate at the efficacy of specific interventions and the cost savings associated with specific and overall preventive interventions. It is critical that to collect good data on efficacy and costs

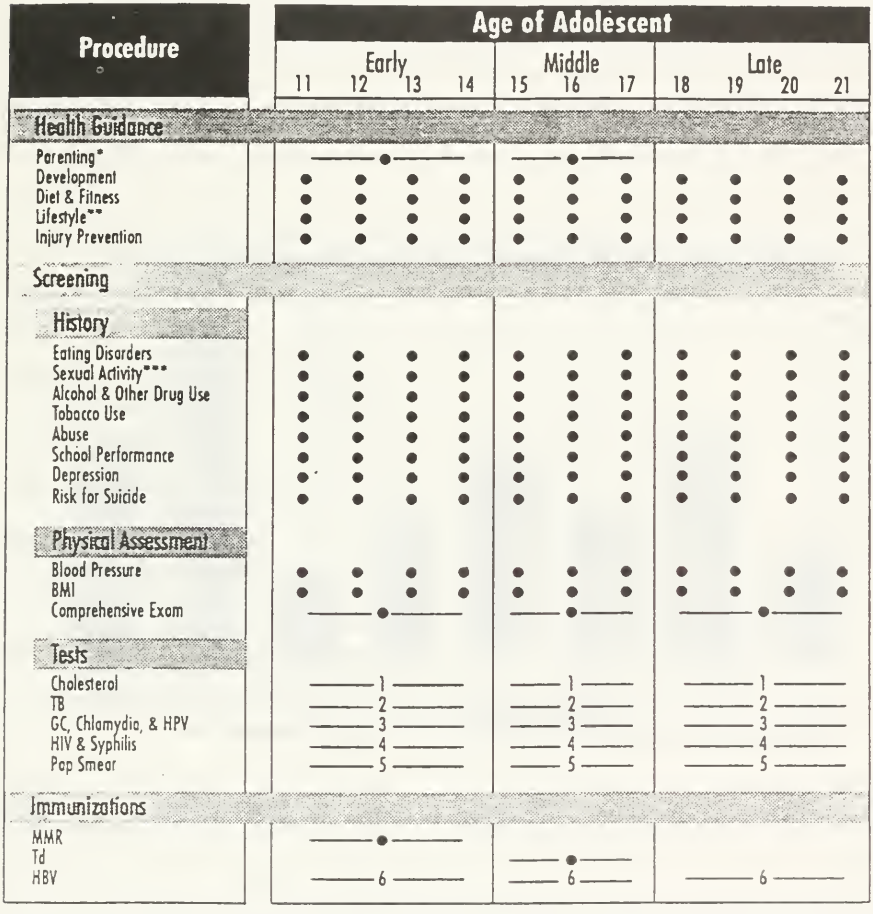
associated with clinical adolescent preventive services.

Adolescent clinical preventive care is not a panacea. The prevention of disease and morbidity and mortality among this age group requires a multi-faceted approach that includes health education and health care by the public health sector, schools, the family, and social service agencies. Research has shown that prevention works best when messages from various sources are consistent and mutually reinforcing. Medicine has an important role to play in this process.

Historically, the one-on-one medical encounter has been underutilized as a forum to explain, discuss, and reinforce preventive care with patients. However, it provides patients with an opportunity to discuss individual questions, concerns, and behavior with medical providers in a confidential setting. It provides medical providers with an opportunity for early detection and early intervention in health-threatening behavior. At $73 to $120 per adolescent per year, clinical preventive services can be an affordable and especially valuable set of services for adolescents.

Fig. 1--- **Guidelines for Adolescent Preventive Health Services**

Adolescents and young adults have a unique set of health care needs. The recommendations for Guidelines for Adolescent Services (GAPS) emphasize annual clinical preventive services visits that address both the developmental and psychosocial aspects of health, in addition to traditional biomedical conditions. These recommendations were developed by the American Medical Association with contributions from a Scientific Advisory Panel, comprised of national experts, as well as representatives of primary care medical organizations and the health insurance industry. The body of scientific evidence indicates that the periodicity and content of preventive services can be important in promoting the health and well-being of adolescents.



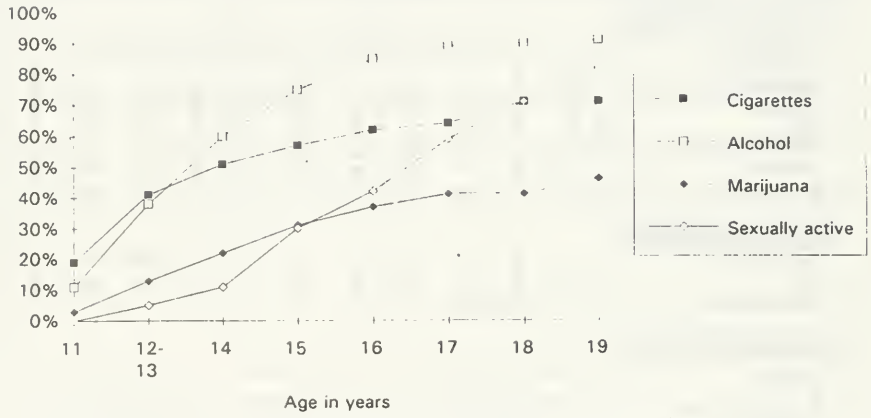
1. Screening test performed once if family history is positive for early cardiovascular disease or hyperlipidemia.
2. Screen if positive for exposure to active TB or lives/works in high risk situation, e.g. homeless shelter, jail, health care facility.
3. Screen at least annually if sexually active.
4. Screen if high risk for infection.
5. Screen annually if sexually active or if 18 years or older.
6. Vaccinate if high risk for Hepatitis B infection.

* A parent health guidance visit is recommended during early and middle adolescence.

** Includes counseling regarding sexual behavior and avoidance of tobacco, alcohol and other drug use.

*** Includes history of unintended pregnancy and STD.

Fig 2.---Adolescent participation in select risk behaviors[11,12,*]



*Unpublished data provided by Susheela Singh of the Alan Guttmacher Institute, November 1993.

Fig 3.---Prevalence of select risk behaviors among 9th-12th grade students[14-19]

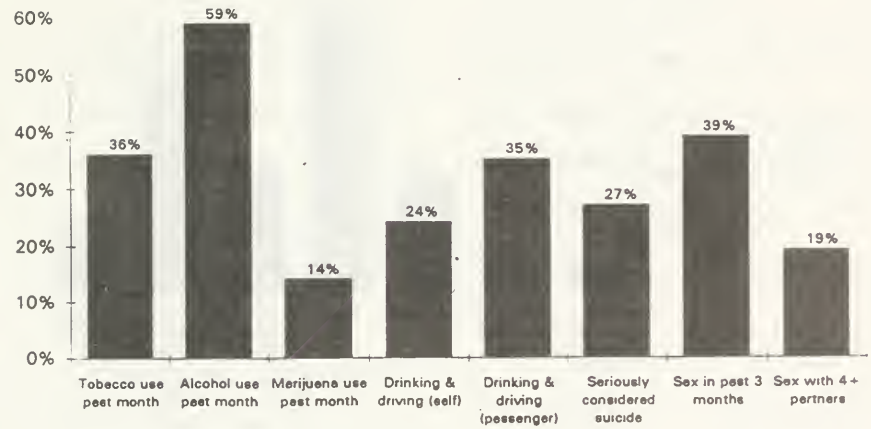


Fig 4.---Prevalence of serious health problems among adolescents resulting from risk behavior [18, 20 24]

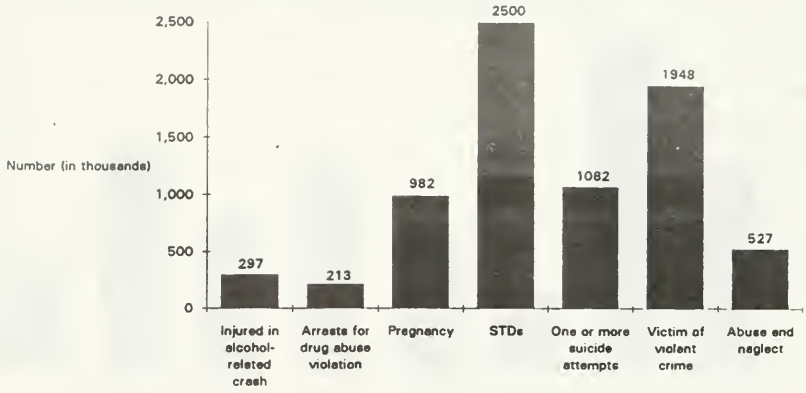


Fig 5.---Estimated single-year treatment costs of select preventable health problems among adolescents, in 1992 Dollars

	Morbidity	Cost	Age Range
1.	Adolescent Pregnancy		
	• Abortion	$173 million	15 - 19 year olds
	• Hospital costs for low birth weight infants	$2.3 billion	15 - 19 year olds
	• Physician and delivery costs:		
	Normal delivery	$2.4 billion	15 - 19 year olds
	Caesarean section	$752 million	
2.	Treatment for sexually transmitted diseases	$882 million	15 - 19 year olds
3.	Treatment for AIDS	$37 million	13 - 19 year olds
4.	Treatment for HIV	$122 million	16 - 21 year olds
5.	Alcohol and drug treatment	$271 million	?
6.	Motor vehicle injuries (Alcohol-involved only)	$13.1 billion	10 - 21 year olds
7.	Unintentional injuries (excluding motor vehicle injuries)	$10.4 billion	15 - 24 year olds
8.	Mental health treatment	$3.9 billion	10 - 18 year olds
TOTAL		$34.2 billion	

Total no. of 11- to 21-year-olds in 1990 = 39,041,721

$34.2 billion/39,041,721 = $877 estimated direct medical treatment costs per adolescent per year

Table 1.---Schedule of visits and tests

MALES Age	Screening tests and immunizations*	Estimated percent of adolescents who are sexually active	Estimated percent of adolescents at high risk for STDs**	CPT code for length of visit
11	MMR, TB, HBV			99214
12				99215
13		25%	6.3%	99214
14		30%	7.5%	99214
15		37%	9.4%	99214
16	Td, 50% cholesterol	50%	12.5%	99215
17		66%	16.5%	99214
18		72%	18.0%	99214
19		86%	21.5%	99215 (optional)
20		90%	22.5%	99214
21	50% cholesterol	95%	23.8%	99214

FEMALES Age	Screening tests and immunizations*	Estimated percent of adolescents who are sexually active	Estimated percent of adolescents at high risk for STDs**	CPT code for length of visit
11	MMR, TB, HBV			99214
12				99215
13		7%	1.8%	99214
14		15%	3.8%	99214
15		26%	6.5%	99214
16	Td, 50% cholesterol	32%	8.0%	99215
17		51%	12.8%	99214
18		69%	17.3%	99214
19		75%	18.8%	99215 (optional)
20		80%	20.0%	99214
21	50% cholesterol	88%	22.0%	99214

*Assumes all adolescents between 11 and 17 years of age should receive a second a vaccination against hepatitis B, a tuberculin skin test, a diptheria-tetanus booster, and that half of all adolescents need a serum cholesterol test every five years.

**Sexually active males should receive a leukocyte esterase test. Sexually active females should receive a Pap smear and be tested for chlamydia and gonorrhea. Males and females at high risk for STDs should be tested for HIV and syphillis.

Table 2.---Fees paid by insurance companies to physicians

Service	CPT code	Number of Insurers Responding	1992 Average Fees	Charges for tests and immunizations by labs and pharmaceutical companies*
Leukocyte Esterase	81007	2	$14	$7.25
Cholesterol	82465	13	$17	$6.25
HIV test	86312	7	$51	$34.50
TB skin test	86580	2	$19	$5.00
Syphillis	86592	8	$18	$5.75
Gonorrhea	87072	8	$27	$14.50
Chlamydia	87110	13	$47	$7.25
Pap Smear	88150	13	$21	$9.25
MMR	90707	12	$44	$35.45
Td	90718	10	$14	$6.50
HBV (3 vaccines)	90731	8	$171	$126.39
45-minute office visit	90215			
30-minute office visit	90214			

*Assumes minimal administrative charges

Table 3.---Total payments by insurance companies to providers for GAPS services, 100% participation

Age	1990 Total, U.S. males	Payments for routine costs ($1,000's)	High risk costs ($1,000's)	Total costs ($1,000's)	1992 annual costs per person
11	1,771,334	$538,486	0	$538,486	$304
12	1,752,999	157,770	0	157,770	90
13	1,706,417	119,449	13,331	132,781	78
14	1,662,245	116,357	15,584	131,941	79
15	1,705,780	119,405	19,990	139,394	82
16	1,697,995	176,591	40,964	217,556	128
17	1,758,400	123,088	36,267	159,355	91
18	1,862,377	130,366	41,903	172,270	93
19	2,078,146	187,033	55,850	242,883	117
20	2,044,082	143,086	57,490	200,576	98
21	1,947,811	152,903	57,826	210,729	108
Total Males	19,987,586	$1,964,534	$339,205	$2,303,739	$115
U.S. Females					
11	1,684,181	$511,911	0	$511,911	$304
12	1,670,451	150,341	0	150,341	90
13	1,632,583	114,281	12,828	127,109	78
14	1,580,862	110,660	26,618	137,278	87
15	1,615,829	113,108	47,158	160,266	99
16	1,606,895	167,117	71,378	238,495	148
17	1,651,662	115,616	94,554	210,170	127
18	1,778,861	161,876	104,637	266,513	150
19	1,998,070	221,786	127,752	349,537	175
20	1,965,332	178,845	134,036	312,881	159
21	1,869,409	186,006	140,245	326,249	175
Total Females	19,054,135	$2,031,628	$759,203	$2,790,831	$146
Total Males and Females		$3,996,162	$1,098,408	$5,094,570	$130

Table 4.---Total costs of provider payments for GAPS recommendations, 100% participation*

Age	1990 Total, U.S. males	Payments for routine costs ($1,000's)	High risk costs ($1,000's)	Total costs ($1,000's)	1992 annual costs per person
11	1,771,334	$419,523	0	$419,523	$237
12	1,752,999	157,770	0	157,770	90
13	1,706,417	119,449	7,386	126,835	74
14	1,662,245	116,357	8,633	124,990	75
15	1,705,780	119,405	11,074	130,479	76
16	1,697,995	163,857	20,005	183,861	108
17	1,758,400	123,088	20,092	142,180	81
18	1,862,377	130,366	23,215	153,581	82
19	2,078,146	187,033	30,941	217,974	105
20	2,044,082	143,086	31,849	174,935	86
21	1,947,811	142,434	32,035	174,469	90
Total Males	19,987,586	$1,822,367	$185,230	$2,007,597	$100
U.S. Female					
11	1,684,181	$432,565	0	$432,565	$257
12	1,670,451	116,932	0	116,932	70
13	1,632,583	146,932	4,693	151,625	93
14	1,580,862	110,660	9,737	120,397	76
15	1,615,829	145,425	17,251	162,676	101
16	1,606,895	122,927	26,136	149,064	93
17	1,651,662	148,650	34,589	183,238	111
18	1,778,861	140,975	39,047	180,022	101
19	1,998,070	198,308	47,673	245,981	123
20	1,965,332	155,753	50,018	205,770	105
21	1,869,409	191,381	52,334	243,715	130
Total Females	19,054,135	$1,910,508	$281,477	$2,191,985	$115
Total Males and Females		$3,732,875	$466,707	$4,199,582	$108

*Assuming no mark-up for tests and vaccines

Table 5.---1992 annual premiums for GAPS services*

	Assuming 50% participation		Assuming 75% participation	
	Per child	Per family	Per child	Per family
Using 1992 Insurance Fees	$73	$36	$110	$54
Assuming no mark-up for tests and vaccines	$61	$30	$91	$45

*Using 12.5% average administrative expenses

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STATEMENT OF THE HOME HEALTH SERVICES & STAFFING ASSOCIATION

JAMES C. PYLES, COUNSEL,
Washington, DC.

Dear Sirs: Attached please find a statement of principles supported by the Market Access and Consumer Choice Coalition, of which the Home Health Services and Staffing Association (HHSSA) is a member, with respect to amendment of the antitrust laws under health care reform.

HHSSA opposes any amendment weakening the antitrust laws for the reason that it would erode patient choice and deprive qualified providers of access to the health care market. It is HHSSA's view that competition among health care providers should be preserved in order to promote cost effectiveness, quality, and innovation in the health delivery system.

We request that the Finance Committee incorporate the principles set forth in the attached paper in any health reform legislation it may consider. We would be pleased to answer any questions or provide any additional information the Committee might request.

Sincerely,

JAMES C. PYLES.

Enclosure:

MARKET ACCESS AND CONSUMER CHOICE COALITION

The Market Access and Consumer Choice Coalition (MACCC) is a coalition of consumer and provider groups and associations that believe that quality, cost effectiveness, and innovation in the health care delivery system can best be ensured by preserving competition among providers as well as among health plans. MACCC members further believe that competition can be preserved only by affording consumers a meaningful choice of qualified providers where possible and ensuring that qualified providers have access to the health care market so they can demonstrate their merit to consumers.

Accordingly, MACCC urges Congress to incorporate the following principles into any health reform legislation:

I. PROTECTION OF COMPETITION UNDER THE ANTITRUST LAWS SHOULD BE PRESERVED

A. Anti-Competitive Activity Should Not Be Authorized

Any health reform legislation should state expressly that no provision in the Act is intended to authorize an activity or arrangement that would be prohibited under the antitrust laws. All proposals for exceptions, exemptions, and waivers should be rejected.

B. Procedures Should Be Established to Provide Greater Certainty and Clarity Under the Antitrust Laws

Greater certainty and clarity in the interpretation and application of the antitrust laws should be promoted by

(1) Providing for an expedited business review procedure under which the Federal Trade Commission and the Department of Justice would respond promptly to requests for advance rulings concerning whether certain activities and arrangements would violate the antitrust laws; and

(2) Providing for a process under which the Federal Trade Commission and the Department of Justice could issue antitrust enforcement guidelines based upon either their own initiative or when petitioned by private parties.

Rationale

The antitrust laws are designed to be sufficiently flexible to protect competition in furnishing all types of products and services under an infinite range of market conditions. These laws are the product of a century of experience and are the embodiment in the economic sector of a fundamental principle of our system of government—equal opportunity under the law.

The promotion or preservation of competition in the health care delivery system is a basic concept in most of the health reform proposals. Only by preserving competition can Congress hope to enhance quality while controlling costs and encouraging innovation.

The antitrust laws should not be weakened by creating exceptions for certain professionals, providers, or activities. There is no reliable evidence that weakening the antitrust laws will reduce the cost of health care. Further, any exception for one type of professional, provider, or activity would surely be enlarged to include others. For example, if physicians were permitted to engage in price fixing, then other pro-

fessionals and providers would claim the same privilege. Then health plans might assert the same right. The exceptions might well then have to be expanded beyond the health delivery area.

Any discussion of amending and weakening the antitrust laws is premature since it is unclear what type of health reform plan will be approved by Congress. For example, it would make little sense to amend the antitrust laws if health care reform amounted merely to incremental reform of the health insurance laws. Before taking such a drastic step, Congress should try less drastic measures such as providing for prompt rulings and issuance of clarifying enforcement guidelines.

II. PATIENT CHOICE AND MARKET ACCESS WITHIN HEALTH PLANS SHOULD BE PRESERVED

A. Health Plans Should Be Prohibited From Restricting Market Access and Reducing Patient Choice

Health plans, including integrated delivery systems, possessing market power, defined as 20% or more of the product or service market within a contiguous geographic service area, must provide an opportunity for participation by a sufficient number of unrelated providers to provide patients a meaningful choice based upon objective competitive criteria which are consistent with the purposes of the statute.

(1) The burden of proof will be on the health plan to demonstrate that it either does not have market power or that it has made participation available based on objective competitive criteria.

(2) Any health plan which elects to make participation determinations based on objective competitive criteria must make the criteria known sufficiently in advance to afford all interested providers a fair opportunity to qualify for available openings.

(3) Health plans possessing market power must provide an opportunity at least every two years for any interested provider, including those participating in the health plan, to demonstrate that they can fulfill the selection criteria better than other providers.

(4) Health plans with market power must provide patients with a choice of unrelated providers, where available, and must honor the patient's selection of a provider.

Rationale

Health reform legislation should balance the desire to allow integrated delivery systems and managed care plans the opportunity to prove their validity in the marketplace against the right of patients to be able to obtain the health care of their choice.

There can be no meaningful choice for patients if providers are deprived of market access. Market access and patient choice become increasingly restricted as health plans attain significant market power. Accordingly, this proposal allows integrated delivery systems and managed care systems to operate with few restrictions so long as they do not exceed the market power threshold. Once they do, they assume a responsibility to the public to ensure that patients will continue to be able to select their providers based on the public policy objectives contained in the statute.

The burden properly rests on the health plans to demonstrate that they are below the market power threshold or have applied the objective criteria because they generally will possess the market data and will have control over whether they are above the threshold. Congress must avoid the situation where an integrated delivery system is permitted to gain market power, foreclose competitors from the market, and eliminate consumer choice. In such a case, patients will be forced to obtain health care from a provider based on corporate affiliation rather than on sound public policy objectives such as quality, cost, and patient satisfaction.

B. Network Health Plans Should Be Required to Adopt Provider Contracting Procedures That Preserve Patient Choice and Market Access

(1) Contracts between network health plans (as defined in §1402(f) of the Health Security Act) and providers should be based on full and open competition. Determinations by network health plans to enter into contracts with providers should be made under an open competitive process which utilizes objective selection criteria for each type of good or service furnished including quality, price, and patient satisfaction.

(2) Network health plans should be precluded from using selection criteria which directly or indirectly discriminate against any health provider on the basis of type, class, or category of provider, or based on whether the provider is affiliated with a hospital or related entity.

Rationale

These provisions are intended to ensure patient freedom of choice and provider market access with respect to network health plans that provide benefits through contracts with providers.

The intent of these provisions is to afford qualified providers maximum opportunity to compete for contracts with network health plans through the use of the following procedures:

(i) advance publication of objective selection criteria;

(ii) advance public notice of when applications for participation are to be accepted;

(iii) limiting the evaluation of applications to the published criteria;

(iv) verification that providers have the capacity to accommodate the patients that the plan will be directing to them and that the quality of service provided will not be compromised by the price negotiated or by increased utilization;

(v) periodic evaluations of participating providers and an "open season" at least every two years in which non-participating providers will have an opportunity to demonstrate that they can fulfill the selection criteria better than participating providers; and

(vi) meaningful due process protections prior to termination or non-renewal of a provider contract.

III. ALL HEALTH PLANS SHOULD BE REQUIRED TO PRESERVE ACCESS TO OUT-OF-NETWORK HEALTH CARE PROFESSIONALS AND PROVIDERS

A. All Health Plans Must Offer A "Point-of-Service" Option

All health plans should be required to offer a "point-of-service" option to preserve patient choice and access with respect to out-of-network health care professionals and to enable such professionals to refer enrollees to out of network providers as deemed necessary, subject to reasonable patient premium and cost sharing requirements.

Rationale

Requiring health plans to provide a point of service option which is not subject to unreasonable coinsurance requirements should ensure that the patient's fundamental right to purchase the health care of his or her choice is preserved and that competing providers will be available when another opportunity becomes available to participate in a health plan.

IV. ENFORCEMENT

The entity charged with certifying the compliance of health plans with the requirements of the health reform act should ensure that health plans are in compliance with the foregoing requirements listed in I., II., and III. as a condition of being permitted to offer benefits under the Act.

STATEMENT OF THE FEDERATED AMBULATORY SURGERY ASSOCIATION

ABOUT AMBULATORY SURGERY CENTERS

Ambulatory surgery Centers (ASCs) developed as an alternative to hospital care and traditional medical service delivery. The ASC industry has grown in scope and size since its inception in 1970. The term "freestanding ASC" refers to both the location of these facilities and the services provided. Freestanding ASCs are generally situated outside of hospitals, and may be located in specially designed, single unit buildings or in office complexes. Freestanding ASCs have fully equipped operating rooms that meet hospital standards and provide all related facility services necessary for the performance of outpatient surgery. ASCs are completely separate and distinct entities from physicians' professional practices, both operationally and organizationally; while many ASCs are owned, in whole or in part, by the physicians who use them, others are organized as separate partnerships or corporations whose ownership structure does not include physicians in any way.

ASCs are now an accepted and established component of our health care delivery system. In 1992, approximately 2,870,000 surgical procedures were performed in ASCs—over 17% of all surgical procedures and approximately one-third of all outpatient surgical procedures. There are currently approximately 1,700 Medicare-certified or state-licensed ASCs located throughout the country, and the number of ASCs is expected to exceed 2,000 by 1995.

The containment of health care costs has never been more important. With health care costs rising at a rate substantially higher than inflation, the Nation must find an alternative to costly hospital care. Surgery centers unequivocally provide that alternative. A 1993 study of freestanding ASCs conducted by SMG Marketing Group, an independent research organization, indicates that, in 1992, the total average charge per case in a freestanding ASC was approximately $931, while the total average charge per case for hospital-owned ASCs was approximately 25% higher.

The charges generated by hospital outpatient departments are higher still. On average, procedures at freestanding ASCs cost 47% less than those same procedures at hospitals, according to a study conducted by Blue Cross/Blue Shield of North Carolina. This study showed that facility fees for the removal of tonsils, for example, average $464 in an ASC, compared with $998 in a hospital. Likewise, repair of an inguinal hernia, which costs an average of $601 in an ASC, costs over twice this amount in a hospital. Cataract surgery costs an average of $835 in an ASC, compared with $2,012 in a hospital.

Freestanding ASCs perform high quality surgical services at lower costs than hospitals because they maintain low overhead costs and because they can focus on one thing: treating ambulatory patients efficiently. This specialization allows efficient use of personnel and facilities.

These cost savings are not achieved by sacrificing quality. ASCs are the most highly regulated providers of ambulatory medical care. All centers approved for Medicare reimbursement must undergo rigorous inspection for compliance with federal standards, and ASCs in 41 states require state licensure as well. In addition, many ASCs choose to become accredited through the Accreditation Association for Ambulatory Health Care or through the Joint Commission for the Accreditation of Health Care Organizations. ASCs are among the only ambulatory care facilities that are subject to Medicare review by peer review organizations. In a 1988 study, the U.S. Department of Health and Human Services' Office of the Inspector General ("HHS OIG") found that ASCs and hospital outpatient departments provide "equally safe environments." The OIG further found that Medicare patients prefer ASCs to hospitals for outpatient surgical care.

ANTICOMPETITIVE BEHAVIOR IN THE MARKETPLACE

ASCs are entirely willing to compete with, and, indeed, participate in, hospital-sponsored programs on the basis of price and quality. Yet, in many parts of the country, hospitals have actively sought to prevent ASCs from offering their services to managed care plans, insurers, and employers. In some markets, dominant hospitals have demanded that managed care plans name them as the exclusive provider of outpatient care, as a condition of providing inpatient services. Because a managed care plan cannot be without a source of inpatient services, plans presented with such a demand often have little choice. As a result, ASCs are eliminated from the managed care arrangement, despite their high quality and lower costs. In other markets, hospitals have developed their own HMOs and PPOs that categorically refuse to contract with ASCs, even though ASCs could provide outpatient surgical care for substantially less than the sponsoring hospitals.

FASA and the Nation's 1,700 ASCs fear that such cost-increasing, anti-competitive arrangements can only become more common under any health care reform plan that increases the power of managed care plans. Over the long run, these exclusionary arrangements will drive ASCs from the marketplace, reducing competition and increasing the cost of care.

RECOMMENDATIONS

FASA understands that, to address these issues, many groups have advocated a requirement that payors permit "any willing provider" to join their networks. We recognize that, to many observers, such remedies would be inconsistent with the basic strategy of managed competition. Nevertheless, we believe it is reasonable for legislation to include provisions to ensure that health plans' contracting procedures work to the benefit of patients and the health care system as a whole. We believe that any health reform legislation enacted by Congress embody the following principles:

- *Full and Open Competition.* Any health care reform legislation should require network health plans to utilize full and open provider selection criteria for each type of good or service furnished, based on objective selection criteria, including the quality and price of, access to, and patient satisfaction with the service.
- *No Discrimination.* Any health care reform legislation should preclude network health plans from establishing provider selection criteria which directly or indirectly discriminate against any health provider on the basis of the type, class

or category of that provider, or based on whether or not the provider is affiliated with a hospital or related institution.

- *Choice of Providers.* Any health care reform legislation should require network health plans to contract with an appropriate mix and adequate number of qualified unrelated, hospital-based and freestanding providers within each type, class, or category of provider within the geographic area of the plan and should preclude such health plans from entering into exclusive contracts with particular providers.
- *No Exclusive Tying.* Any network health care reform legislation should preclude network health plans from agreeing with a provider to utilize the outpatient services furnished by such provider exclusively as a condition of utilizing such provider's inpatient services.
- *Enforcement.* Any health reform legislation should require that any entity charged with certifying health plans should ensure that each health plan, as a condition of certification, complies with the applicable provider contracting requirements.
- Any health care reform legislation should require health plans to provide "point of service" policies that facilitate access to out-of-network health care professionals and that enable such professionals to refer enrollees to out-of-network providers, subject to reasonable patient premium and cost sharing requirements.

This proposal is also supported by a coalition which now includes a wide range of associations with similar concerns including, for example, the American Clinical Laboratory Association, the National Association of Medical Equipment Services, the American Federation of Home Health Agencies, the Quality Imaging Association, the American Academy of Facial, Plastic and Reconstructive Surgery, the Outpatient Ophthalmic Surgery Society, the American Society of Outpatient Surgeons and the Association of Freestanding Radiation Oncology Centers.

In addition, FASA believes that the antitrust laws should remain intact and provider-sponsored networks should be precluded from obtaining antitrust immunity under the "state action" doctrine. If a mechanism is provided for a provider-sponsored network to seek the protection of an "antitrust safety zone," such protection should not be granted unless the network demonstrates that:

- The network has afforded all providers a full and fair opportunity to participate in the network in accordance with the procedures set forth above.
- The establishment of the network will not impair competition over the long run, by substantially reducing the number of freestanding providers within a service area.

By ensuring that contracting procedures remain competitive, these measures provide the best method of achieving the goal we all share: high-quality, cost-effective health care for all Americans.

Statement of the Washington Business Group on Health

INTRODUCTION

The Washington Business Group on Health (WBGH) appreciates this opportunity to submit our comments on medical malpractice and antitrust issues in health system reform. WBGH is an organization of Fortune 500 employers that has been involved in public- and private-sector efforts to improve health care delivery and financing since 1974. WBGH member companies provide health benefits to approximately 30 million Americans.

The WBGH encourages Congress to enact comprehensive medical malpractice reforms to redress the inefficiencies and inequities embodied in the current malpractice system. We also urge Congress to avoid statutory antitrust exemptions that would weaken the protection afforded consumers by the current antitrust laws and to encourage the agencies with enforcement authority to continue providing guidance and clarification on the application and enforcement of these laws.

MEDICAL MALPRACTICE REFORM

The current medical malpractice system falls far short of its primary goals: it does not effectively deter negligent medical care; it reduces access to needed services while increasing utilization of costly, inappropriate care that can actually threaten patients' health; and it resolves claims in an inefficient and inequitable manner. As a result, the malpractice liability system is in need of fundamental reform.

The time for reform is now. Although the cost of malpractice insurance and the number of claims paid have stabilized or declined in recent years, there is little reason for satisfaction with the status quo. Claims and premiums remain far higher than they were a decade ago. The system continues to perform very poorly in the three ways specified above. Until we make structural changes in the malpractice liability system, it will continue to hold patients, providers and payers at unjustified risk.

Flaws in the Current Malpractice Liability System

FAILURE TO DETER NEGLIGENT CARE

A principal purpose of the medical liability system is to deter negligent care. While the incidence of negligent care is difficult to measure, it appears that the current liability system does not effectively reduce medical negligence.

The two major studies of the incidence of medical malpractice cover California hospital discharges in 1974 and New York hospital discharges in 1984. Both found provider negligence in about 1% of cases. National data indicate that between 1974 and 1984 the frequency of claims made against physicians rose by about 300%. Malpractice insurance premiums also rose dramatically. If the malpractice system had been operating as an effective deterrent, we would have expected a significant decrease in the number of negligently treated patients. But that did not materialize. A well-designed alternative system should serve as a much more effective deterrent to negligence.

Inappropriate, unnecessary and poor quality health care—*whether or not classified as negligent* under standards of care that are often poorly defined—is a major problem that permeates our health care system. However, for a variety of reasons (e.g., arbitrary results, vague standards of care, the filing of many non-meritorious claims and long lag times between the provision of negligent care and resolution of claims) the current malpractice liability system contributes little to quality improvement and even creates incentives to practice poor quality medicine. Again, a well-designed alternative should achieve better results.

REDUCED ACCESS TO NEEDED SERVICES

The current malpractice liability system has placed high barriers in front of poor women and women living in underserved areas when they seek prenatal care. In a country with a shamefully high infant mortality rate, this result makes little sense, especially since the rate of negligent obstetrical care is known to be extremely low.

Malpractice costs also limit access to care by the burden they place on Community Health Centers, which are sometimes the only provider of services for vulnerable populations, including poor pregnant women, HIV-infected persons and homeless persons. In 1989, Community Health Centers' malpractice premiums equalled 10% of the total federal grant funds awarded to the centers.

PROMOTION OF DEFENSIVE MEDICINE

The cost of the current malpractice system encompasses both direct premium costs (used to pay claims and overhead) and the cost of defensive medicine. Premium costs for physicians and hospitals are about $7 billion per year. Notably, the premium cost per physician (roughly $15,000 per year) is about ten times as high in the United States as in Canada.

The cost of defensive medicine (i.e., services rendered to protect the provider against malpractice liability rather than to benefit the patient) is more difficult to calculate, but estimates suggest it is in the range of $10 billion to $20 billion per year. Our poorly structured health care system allows overutilization to profit providers, as well as to protect them against litigation. This points to the need to consider malpractice reform in the context of comprehensive health system reform. At a minimum, eliminating the need for defensive medicine would set the stage for broader efforts to reduce the large amount of inappropriate and unnecessary care now provided to patients.

The use of electronic fetal monitoring during deliveries provides one important example of defensive medicine. According to a recent report, a Utah malpractice insurer found that failure to use fetal monitors was one of the delivery practices implicated in the bulk of successful malpractice claims. The insurer now requires all of the physicians it covers to use fetal monitors in all deliveries. Yet two years ago the Institute of Medicine reported that studies of fetal monitoring "do not support [its] effectiveness in reducing neonatal mortality and morbidity."

Defensive medicine is not only costly, it also often harms patients. Extra procedures carry extra risk. One study found that Caesarean section rates increase as malpractice premiums go up. Caesarean sections are related to more maternal deaths and illnesses than vaginal deliveries, as well as unnecessary medical and disability costs, lost wages and unnecessary pain and suffering. The Institute of Medicine has noted a correlation between fetal monitor use, which is stimulated by the current malpractice system, and Caesarean section rates.

INEFFICIENCY AND INEQUITY

The malpractice liability system incurs extraordinarily high transaction costs. Studies estimate that only about 30% of premium payments reach claimants as compensation. The remainder is spent on administrative costs, including the cost of defending claims, and plaintiffs' attorneys' fees. Malpractice defense costs have skyrocketed. Between 1980 and 1984 they rose by 400%, a much higher rate than experienced in other types of liability claims.

Much of the system's excessive and wasteful administrative cost is incurred because it does so poorly at deterring the filing of non-meritorious claims, and at winnowing out such claims before they go to trial. About three of every five claims are closed without any payment for damages to the claimant, but after generating administrative costs. Plaintiffs win between 20% and 40% of cases that reach the trial stage, compared to more than 60% for other types of liability cases. This record suggests that inappropriate incentives drive the medical liability system and encourage non-meritorious claims. And the system's poor screening of claims does not end with jury decisions; medical malpractice awards are more likely than other types of liability awards to be reduced after the verdict.

The system's inequities are as striking as its inefficiencies. The Harvard study of negligence in New York hospitals found that fewer than 1 out of 16 malpractice victims receives compensation. In fact, most never file claims (though half the claims that were filed were determined to be without merit). The import of this finding should not be exaggerated. In fact, the large majority of malpractice victims sustained only minor harm, while others who were harmed more severely incurred only limited financial damages. It is also likely that some injured persons recover most of their losses from collateral sources, such as health and disability insurance. Nonetheless, it is clear that some persons with substantial injuries and damages caused by negligence do not receive compensation.

WBGH's Medical Malpractice Liability Reform Proposal

WBGH urges Congress to consider the following reform measures to address the weaknesses of the current medical malpractice system.

COMPREHENSIVE REFORM

Malpractice reform must be comprehensive in scope. Reform that is less than comprehensive will shift liability among parties, but will not correct the system's root problems.

Employer Liability in Managed Care Settings

Historically, employers had not been the targets of suits seeking recovery for injuries caused by medical negligence. However, in recent years a number of court decisions have extended liability for injuries caused by negligent care to third party payers, based on their role in managing patient care. There are early indications that some courts may go even further by extending corporate negligence and related theories of liability to employers when employees are negligently injured while receiving treatment through employer-selected managed care plans. Therefore, any malpractice-related claim brought against an employer under state law, regardless of the legal theory on which it is based, should be subject to the same reforms concerning awards, alternative dispute resolution, attorney contingency fees and statute of limitation that apply to claims against health care providers.

Managed Care Organizations and HMOs

Similarly, malpractice-related claims brought against managed care organizations and HMOs under state law should be subject to reforms concerning awards, alternative dispute resolution, attorney contingency fees and statute of limitation.

FEDERAL ACTION

Years of state experiments with limited tort reforms has produced some partial successes, but have not produced comprehensive change. Based on what is at stake for the federal government, multi-state employers, multi-state managed care provid-

ers and multi-state malpractice insurers and the relationship of malpractice reform to comprehensive health system reform, the time for federal action has arrived.

As the details of managed competition are developed, the regional nature of accountable health plans considered. If an accountable health plan covers more than one state, state-by-state malpractice reform will freeze in place current problems experienced by multi-state organizations.

RESOLUTION OF CLAIMS THROUGH ALTERNATIVE DISPUTE RESOLUTION

The current court-based system of malpractice litigation should be replaced by a mandatory alternative dispute resolution process designed to speed up claims resolution, to bring greater expertise and consistency to fact-finding and decisions and to reduce transaction costs. A system that meets these criteria will compensate more injured persons and discourage non-meritorious claims. It will encourage earlier settlement through greater consistency of decisions. And it will help to more clearly define the standards of care for providers.

A well designed alternative dispute resolution process should replace the inefficient and inequitable court-based resolution of malpractice claims, not add another costly layer to the present system. Therefore, while the parties should be permitted to appeal from the final agency decision to the courts, the appeal should not give the parties an opportunity to "retry" the case de novo. The court that receives appeals should have discretion in deciding which cases to take and should apply a high standard of review.

ENTERPRISE MEDICAL LIABILITY

The malpractice liability system should encourage high quality care as a means of reducing the incidence of malpractice. Poor quality, inappropriate and negligent medical care are not simply the results of bad services from individual providers. They are also the predictable outcome of a fragmented medical care delivery system that is driven by perverse incentives. Traditional malpractice litigation focuses on negligent individuals. It has done little to address the systemic causes of negligent and other poor quality care.

To improve quality and to reduce the incidence of negligent care, health system reform legislation must go beyond redesigning the malpractice liability system and address the underlying flaws in the way health care is delivered. As the delivery and financing of health care services and products become increasingly integrated, organized systems of care are being established that use panels of providers selected on the basis of quality and cost-management criteria to furnish members with comprehensive services. These integrated systems incorporate into their operations continuous quality improvement mechanisms and incentives to provide only appropriate and necessary care. They are accountable to both purchasers and patients on the basis of cost, quality and outcome of treatment.

Organized systems of care (OSCs) are in a much better position than individual providers to prevent negligent and other poor quality care. A system of care has greater resources, and an ability to devote those resources, to the detection and prevention of injuries. Malpractice reform legislation should recognize this responsibility by providing that claims against providers who are part of integrated systems of care be filed against the system as well as against the individual provider. System liability would create a strong incentive for OSCs to closely monitor and continuously improve the quality of care.

PRACTICE GUIDELINES

WBGH supports the use of clinical guidelines to improve quality and to address the malpractice liability problem. A guideline-centered approach would recognize the systemic nature of the malpractice problem and attack the causes rather than the symptoms of medical malpractice.

Practice guidelines would improve quality, and thus reduce the incidence of malpractice, by challenging inappropriate treatment protocols. Practice guidelines would also make it easier to resolve malpractice claims by reducing ambiguity in the standard of care that applies to health care providers.

We suggest that practice guidelines be used in the following manner to make malpractice determinations. First, defendants should win dismissal of the case against them if they can prove that (1) they adhered to a practice guideline certified by the Secretary of Health and Human Services, (2) the guideline was the correct guideline to apply and (3) the guideline covers the act or omission alleged to have caused the injury.

Second, plaintiffs should be allowed to raise failure to meet the appropriate certified guideline as a rebuttable presumption of negligence. If there is no certified

practice guideline for the diagnosis or treatment issue, liability would be determined only with reference to other applicable law.

We suggest the following process for establishing practice guidelines to be used in medical malpractice cases.

Practice guidelines would be certified by the Secretary of Health and Human Services, and they would serve as a standard of care for determining malpractice liability. The Secretary would also be responsible for appropriate ongoing review and updating of guidelines. Initially the Secretary might certify a number of acceptable guidelines, but ultimately one national uniform guideline would be certified as the standard for each particular diagnosis for treatment.

Procedural requirements for certification should include establishment of a broad-based advisory panel to advise the Secretary on federally-supported guideline development and certification efforts. Medical specialty society participation in guideline development and certification must be balanced with participation by other key parties. Therefore, the panel should include substantial business and consumer representation.

Practice guidelines should be uniform to the greatest extent practicable, regardless of the source of payment for the patient's care. Reliance on local standards of practice should not be encouraged, although it might be permitted during a transitional period as the guidelines certified by the Secretary are implemented.

CONSTRAINTS ON AWARDS

Mandatory Payment to Collateral Sources

The collateral source rule prohibits the introduction of any evidence in a trial that a patient has been compensated or reimbursed for his injury from any source other than the defendant, such as health or disability benefits. Therefore, plaintiffs can receive double recoveries: from insurers, employers and from defendants.

Double recoveries should be eliminated. Collateral sources should be paid for their expenditures out of the settlement or award. Studies suggest that eliminating double recovery reduces both the frequency of claims and the size of awards by about 15%.

Cap on Non-Economic Damages

As suggested above, malpractice awards do not correlate well with the level of injury sustained by a patient. In addition, non-economic damages, including damages for pain and suffering, loss of consortium and loss of enjoyment of life, substantially exceed damages for monetary losses. Because non-economic damages are difficult to accurately ascertain and are a principal reason for arbitrary variation among malpractice awards, they should be capped at a reasonable level. We emphasize that economic losses resulting from malpractice should remain fully recoverable.

Periodic Payment of Future Economic Damage Awards

Economic damages in excess of $100,000 intended to compensate for future losses (e.g., lost income and future medical expenses) should be paid on a periodic basis rather than in a lump sum. Insurers are better able to appropriately finance large awards under a periodic payment system.

Payment of Punitive Damages

Punitive damages are intended to penalize particularly egregious behavior and deter similar behavior in the future. They are not based on economic or non-economic damages suffered by plaintiffs. Because they are a policy tool rather than a means of compensation, punitive damages should be paid to state agencies that monitor and discipline health providers instead of to patients.

Elimination of Joint and Several Liability

Under the doctrine of joint and several liability, each party is fully liable for the total amount of the award. When one or more defendants are without resources this doctrine may require a defendant with a limited role in causing the injury, but with a "deep pocket," to bear a disproportionate share of compensation. This doctrine can disrupt settlement negotiations and is inherently unfair when defendants are marginally related to the cause of action. Therefore, WBGH advocates elimination of the joint and several liability doctrine for all claims against providers, manufacturers and employers.

CAP ON ATTORNEY CONTINGENCY FEES

WBGH urges Congress to consider a cap on attorney contingency fees based on a sliding scale related to award size. Attorney fees should be calculated on the basis of net proceeds to the plaintiff after payment of litigation expenses.

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Contingency fees are often defended as giving attorneys incentives to screen out non-meritorious cases. However, the data on non-meritorious claims indicates that contingency fees have not performed this function well in the medical malpractice setting. This goal could be better served by a modified fee schedule.

Contingency fees are also defended as a mechanism to improve plaintiffs' access to legal services. However, a 1987 General Accounting Office report suggested that many lawyers will not accept a malpractice case with an anticipated recovery under $50,000. Furthermore, the principle that contingency fees improve access does not require that fees should reach the very high levels found in many cases.

A sliding fee schedule, combined with a lower-cost alternative dispute resolution process, would improve screening of non-meritorious claims and maintain at least the same level of access. A sliding fee schedule would also reduce abuse of the contingency fee system and return a higher portion of awards to injured plaintiffs who need and deserve compensation.

STATUTE OF LIMITATION

WBGH recommends adopting a two year statute of limitation that begins at the time the claimant discovered or should have discovered both the harm and its cause. A statute of repose should also be enacted to provide for an absolute limit on when a case must be brought. Such a policy would avoid the possibility that relevant evidence will become stale because documents are lost, witnesses become unavailable or their clear recollection dwindles. Excessive delay is also disruptive to the insurance underwriting process because it is harder to accurately reserve and price the insurance product when there is a long tail of liability.

This provision should include an exemption for minors under six years of age, so that the statute of limitation does not begin to run until the child's sixth birthday. Abnormalities resulting from any injury should be detected by the time a child reaches school age.

ANTITRUST IN HEALTH SYSTEM REFORM

WBGH urges Congress to maintain the protection afforded by current antitrust laws by avoiding any statutory exemptions for special interests in the health care industry. We also support the enforcement agencies' continued efforts to provide guidance and clarification concerning the application and enforcement of antitrust laws.

The role of antitrust in health system reform should be to enhance access to health care products and services while promoting the delivery of appropriate, high-quality and cost-efficient care. Strong enforcement of antitrust law is the best way to achieve this goal because it would protect against the accumulation and abuse of market power. In the absence of such enforcement, select providers might amass sufficient market power, or a large number of providers might collude together to raise prices, to reduce quality, products or services, to limit consumer choice, or to prevent new competition from entering the market. Health care reform must preserve the power of antitrust law to prevent these anticompetitive results.

The American health care system has been significantly changing for more than a decade, spurred in large part by the demands of purchasers for increased quality and managed costs. Large employers have been working with providers for many years to create health care delivery systems that improve quality while controlling the costs of health care for their employees and for all health care consumers. Antitrust laws play a crucial role in ensuring the continuing development and improvement of these systems while protecting consumers from the ill effects of such anticompetitive conduct as price-fixing, boycotts and monopolies. Antitrust should continuc to allow collaborative health care arrangements that benefit consumers.

The original antitrust statutes are very brief; the rich body of antitrust law has been primarily developed by the courts. This body of law contains the flexibility and protection for providers to collaborate in procompetitive activities, including organizing into OSCs that compete with each other to provide high quality health services and products. Efficiently and at a reasonable cost. The current body of antitrust law also contains the power to prohibit collusive activities that would harm consumers or prevent other providers from competing in the marketplace.

Several pending health reform bills would create special exemptions for providers in the health care industry that could pose significant risks for consumers. These include provisions in the Health Security Act (H.R. 3600/S. 1757), the Managed Competition Act (H.R. 3222/S. 1579) and Health Equity Access and Reform Today Act (H.R. 3704/S. 1770). Allowing providers to collectively negotiate their fees, without any financial risk-sharing or integration on their part, would inevitably lead to higher prices in the fee-for-service sector and eventually among OSCs as well. The

other statutory immunities created in these bills also raise the risk of higher prices, lower quality and reduced access.

WBGH urges Congress to be very cautious when considering any modification of antitrust law in health system reform. Providers are working with one another, and with employers and other purchasers of health care, to improve the quality of and access to health care under the protection of current antitrust law. We emphasize the need to consider quality and access factors in the application of antitrust law and encourage ongoing guidance from the enforcement agencies. But we strongly support the continued enforcement of current antitrust law in health system reform, with no exemptions for special interests.

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